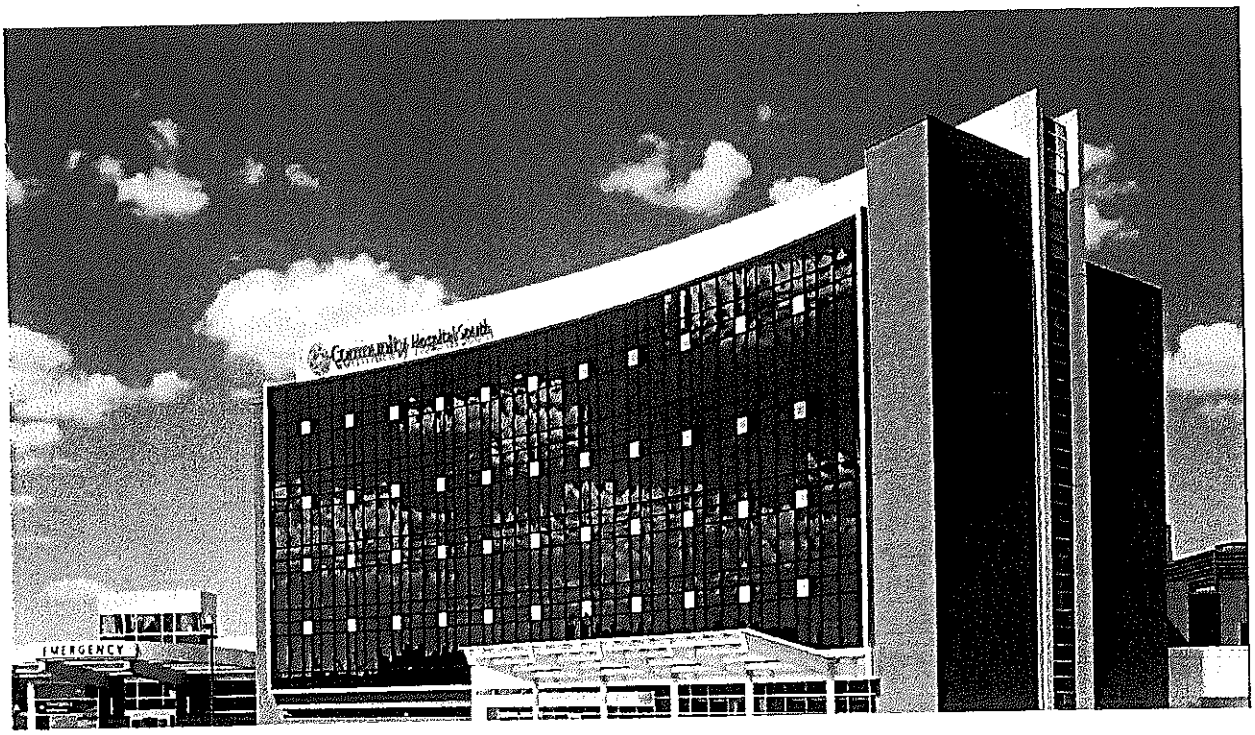
Community Hospital South

Indianapolis, Indiana



APPLICATION

FOR

"IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER

DESIGNATION

July 8, 2014

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Department of Health

2 North Meridian Street

Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee (ISTCC):

Community Hospital South is pleased to submit the attached application packet for consideration to be designated an "In the ACS Verification Process" Level III Trauma Center. Our Trauma Team has worked diligently to provide the ISTCC and the Indiana EMS Commission with complete documentation supporting our designation request.

The documents included in the attached submission demonstrate a strong commitment by our entire staff including our Board – Certified Emergency Physicians, General Surgeons, Orthopedic Surgeons, and Neurosurgeons. We will work together to pursue opportunities for improvement and continue to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Respectfully,

A. B Lennen

Anthony Lennen
President
Community South Region

Edward Diekhoff MD, FACS

Edward Diekhoff, M.D., FACS
Trauma Medical Director

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APPLICATION FOR HOSPITAL TO BE DESIGNATED "IN THE ACS VERIFICATION PROCESS"

State Form 55271 (5-13)

Date submitted *(month, day, year)*
July 8, 2014

APPLICANT INFORMATION		
Legal name: Community Hospital South		
Mailing address *(number and street, city, state, and ZIP code)*: 1402 East County Line Road, Indianapolis, IN 46227		
Business telephone number	24-hour contact telephone number	Business fax number

CHIEF EXECUTIVE OFFICER INFORMATION	
Name: Tony Lennen	Title: Regional President
Telephone number	E-mail address

TRAUMA PROGRAM MEDICAL DIRECTOR INFORMATION	
Name: vard Diekhoff, M.D., F.A.C.S.	Title: Trauma Medical Director
Telephone number	E-mail address

TRAUMA PROGRAM MANAGER INFORMATION	
Name: Roxann Kondrat	Title: Trauma Program Manager
Telephone number	E-mail address

TRAUMA LEVEL BEING REQUESTED *(check one)* ☐ LEVEL I ☐ LEVEL II ☑ LEVEL III

ATTESTATION

In signing this application, we are attesting that all of the information contained herein is true and correct and that we and the applicant hospital agree to be bound by the rules, policies and decisions of the Indiana Emergency Medical Services Commission regarding our status.

Signature	Printed name	Date *(month, day, year)*
Signature of chief executive officer: G. B. Lennen	ANTHONY B. LENNEN	6-19-14
Signature of trauma medical director: Edward Diekhoff MD	Edward DIEKHOFF	6/19/14
Signature of trauma program manager: Roxann Kondrat RN	Roxann Kondrat RN	6-19-14

STRUCTIONS: Address each of the attached in narrative form

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APPLICATION FOR "IN THE ACS VERIFICATION PROCESS" LEVEL III TRAUMA CENTER STATUS

Part of State Form 55271 (5-13)

ospitals that wish to apply for status as an "in the ACS verification process" Level III Trauma Center must provide sufficient documentation for the Indiana Emergency Medical Services Commission to conclude that your hospital complies with each of the following requirements:

1. **A Trauma Medical Director** who is Board-Certified, or Board-Eligible, or an American College of Surgeons Fellow. This is usually a general surgeon who participates in trauma call and is current in Advanced Trauma Life Support (ATLS). The Trauma Medical Director must be dedicated to one hospital.

2. **A Trauma Program Manager**: This person is usually a registered nurse and must show evidence of educational preparation, with a minimum of sixteen (16) hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients.

3. **Submission of trauma data to the State Registry**: The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary data standard within thirty (30) days of application and at least quarterly thereafter.

4. **A Trauma Registrar**: This is someone who abstracts high-quality data into the hospital's trauma registry and works directly with the hospital's trauma team. This position is managed by the Trauma Program Manager.

5. **Tiered Activation System**: There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program.

6. **Trauma Surgeon response times**: Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons. Also, there must be a written letter of commitment, signed by the Trauma Medical Director, that is included as part of the hospital's application. There must be evidence that a trauma surgeon is a member of the hospital's disaster committee.

7. **In-house Emergency Department physician coverage**: The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients.

8. **Orthopedic Surgery**: There must be an orthopedic surgeon on call and promptly available twenty four (24) hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement.

APPLICATION FOR "IN THE ACS VERIFICATION PROCESS"
EVEL III TRAUMA CENTER STATUS *(continued)*

9. **Neurosurgery**: The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for higher levels of care. This plan must be approved by the facility's Trauma Medical Director. There must be a transfer agreement in place with Level I or Level II trauma centers for the hospital's neurosurgical patient population. The documentation must include a signed letter of commitment by neurosurgeons and the Trauma Medical Director.

10. **Transfer agreements and criteria**: The hospital must include as part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals.

11. **Trauma Operating room, staff and equipment**: There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services twenty four (24) hours per day. The application must also include a list of essential equipment available to the OR and its staff.

12. **Critical Care physician coverage**: Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients. There must be prompt availability of Critical Care physician coverage twenty four (24) hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage twenty four (24) hours a day.

13. **CT scan and conventional radiography**: There must be twenty four (24) hour availability of CT scan and conventional radiography capabilities. There must also be a written letter of commitment from the hospital's Chief of Radiology.

14. **Intensive care unit**: There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources to resuscitate and monitor injured patients.

15. **Blood bank**: A blood bank must be available twenty four (24) hours per day with the ability to type and crossmatch blood products, with adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients.

16. **Laboratory services**: There must be laboratory services available twenty four (24) hours per day.

17. **Post-anesthesia care unit**: The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment twenty four (24) hours per day. Documentation for this requirement must include a list of available equipment in the PACU.

18. **Relationship with an organ procurement organization (OPO)**: There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO.

19. **Diversion policy**: The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than five percent (5%) of the time. The hospital's documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion.

20. **Operational process performance improvement committee**: There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year.

21. **Nurse credentialing requirements**: Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU.

22. **Commitment by the governing body and medical staff**: There must be separate written commitments by the hospital's governing body and medical staff to establish a Level III Trauma Center and to pursue verification by the American College of Surgeons within one (1) year of this application and to achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one (1) year of this application and/or does not achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status that the hospital's "in the ACS verification process" status will immediately be revoked, become null and void and have no effect whatsoever.

COMMUNITY HOSPITAL SOUTH
MEDICAL STAFF DEPARTMENT/COMMITTEE STRUCTURE
2013/2014

MEDICAL STAFF OFFICERS:

CHIEF OF STAFF.....Kevin Julian, M.D.
VICE CHIEF OF STAFF.....Chadwick Strain, M.D.
SECRETARY/TREASURER.....Bryan Benedict, M.D.

DEPARTMENT CHAIRMAN/VICE-CHAIRMAN:

ANESTHESIA DEPARTMENT.....Andrew Corsaro, M.D., Chairman
Chad Strain, M.D., Vice-Chrmn.

CARDIOLOGY DEPARTMENT.....H. John Komari, M.D., Chairman
Brad Weinberg, M.D., Vice-Chrmn.

EMERGENCY DEPARTMENT.....Joel Parker, M.D., Chairman
J. Ryan Bence, D.O., Vice-Chrmn.

FAMILY PRACTICE DEPARTMENT.....David Booth,II, D.O., Chairman
Mery Kendall, M.D., Vice-Chrmn.

INTERNAL MEDICINE DEPARTMENT.....Jan Peterson, M.D., Chairman
Ian Scharrer, M.D., Vice-Chrmn.

OB/GYN DEPARTMENT.....David Szentes, M.D., Chairman
Charles Salazar, M.D., Vice-Chrman.

RADIOLOGY DEPARTMENT..... Paul Sheets, M.D., Chairman
A. Jason Mullinix, M.D.,Vice-Chrmn

SURGERY DEPARTMENT..... Paul Jason Bowlds, M.D., Chairman.
Frederick Lane, M.D., Vice-Chrmn.

SECTION CHAIRMAN:

Orthopaedic Section.....Kevin Julian, M.D., Chrmn.
Pathology Section.....Richard Bohnenkamp, M.D., Chrmn.
Pediatric Section.....Sheryl King, M.D., Chrmn.
Podiatry Section.....Michael Carroll, D.P.M., Chrmn.

COMMITTEE CHAIRMAN:

Constitution & Bylaws Committee.....Richard Bohnenkamp, M.D., Chrmn.
Credentials Committee.....David Brown, M.D., Chrmn.
Critical Care Committee.....S. Niazi, MD & F. Abbasi, MD, Co-Chrmn.
Ethics Committee.....George Small, M.D., Chrmn.
Impaired Physicians Committee Open
Infection Control Committee.....Robert Baker, M.D., Chrmn.
Pharmacy & Therapeutics Committee.....Abboud Kawak, M.D., Chrmn.
Professional Standards Committee.....Open
Quality Assurance Committee.....Chad Strain, M.D., Chrmn.
Social Committee.....Open

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Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 1

Trauma Medical Director

1. " **Trauma Medical Director** who is Board – Certified, or Board- Eligible, an an American College of Surgeons Fellow. This is usually a general surgeon who participates in trauma call and is current in Advanced Trauma Life Support (ATLS). The Medical Director must be dedicated to one hospital."

Narrative Response and Discussion

The requirements of section 1 are met with a letter from Edward Diekhoff, M.D. the Community South Hospital Trauma Medical Director. Dr. Diekhoff is a Board-Certified General Surgeon who participates in trauma call. Dr. Diekhoff is dedicated exclusively to the administration of the CHS trauma program. Dr. Diekhoff completed his ATLS training in June of 2014. A copy of the Trauma Medical Director job description is attached.

Community Health Network

ROLE SUMMARY

TITLE/JOB CODE: Trauma Medical Director

DEPARTMENT/COST CENTER: Trauma Program – 67803

REPORTS TO: Chief Medical Officer, Chief Executive Officer

DIRECTLY SUPERVISES: None

REVISION DATE: New 2014

ROLE OVERVIEW	The Trauma Medical Director is responsible for the ongoing development, growth and oversight/authority of the Trauma Program. He/she must be able to demonstrate effective interpersonal skills and an understanding of the interdependent roles of various allied health professions. The Trauma Medical Director is responsible for promoting high standards of practice through development of trauma policies, protocols and practice guidelines; participating in rigorous performance improvement monitoring; staff education and trauma research. He/she has authority to act on all trauma performance improvement and administrative issues and critically review trauma deaths and complications that occur within the hospital. Decisions affecting the care of trauma patients will not be made without the knowledge, input and approval of the Trauma Medical Director.
REQUIRED EXPERIENCE	Three years clinical experience in emergency/trauma care Two years administrative experience preferred
REQUIRED EDUCATION	Board certified surgeon
REQUIRED LICENSE CERTIFICATIONS	Current license to practice medicine in the State of Indiana Current certification in Advanced Trauma Life Support
PRE-REQUISITE SKILLS	Member in good standing of the hospital medical staff Ability to establish and maintain effective interpersonal relationships Ability to accept and implement change Ability to problem solving make decisions Demonstrated history of positive collegial relations with colleagues, support staff, hospital-based providers, administrators and patients.

ESSENTIAL FUNCTIONS

Administration:

- Participate in the research, development and writing of trauma policies, protocols and practice guidelines.
- Implement all trauma program policies and procedures as they pertain to patient care.
- Organize, direct and integrate the trauma program with all other departments and services within the hospital.
- Promote a cooperative and collaborative working environment among the clinical disciplines involved in trauma care.
- Maintain an effective working relationship with the medical staff, trauma service staff, administration and other departments.
- Provide advice and direction in recommending privileges for the trauma service.
- Participate in trauma program marketing activities.
- Establish a physician case management process that fosters cost-effective, high quality patient care.
- Assesses need for equipment, supplies, budget
- Assist the Trauma Program Manager in developing and meeting the trauma program budgetary goals.
- Oversee, participate in and develop projects that ensure the cost-effectiveness of care provided by physicians and hospital.

Program Initiatives:

- Lead efforts to develop and maintain a trauma center.
- Collaborate with the Trauma Program Manager to establish trauma program goals and objectives consistent with those of the hospital and ensure that those of the trauma program are being met.
- Develop and provide input on the development and maintenance of practice guidelines, policies and methodologies for medical/surgical trauma care.
- Participate in site review by regulatory agencies.
- Organize, direct and implement departmental practices to assure continued compliance with applicable laws including the guidelines established by the Statewide Trauma System and the Joint Commission on Accreditation of Hospitals.
- Demonstrate positive interpersonal relationship with colleagues, referral MDs, hospital personnel, and patients/families in order to achieve maximum operational effectiveness and customer satisfaction.
- Assure transfer agreements in place and in good standing; maintain relationship with receiving facilities, foster collaborative relationship.
- Make appropriate referrals for specialty services and communicate regularly with referring physician as appropriate.
- Ensure that adequate attending physician availability is provided to render care to trauma patients.
- Ensure establishment of physician/surgeon call schedules for all

trauma care, excluding those who do not meet educational and credentialing requirements.
- Provide trauma care leadership and consultation for emergency, surgery and intensive care unit departments.
- Participate in regional and statewide activities affecting the trauma program.
- Attend local and national meetings and conferences to remain current regarding issues relevant to the performance of duties.
- Demonstrate consistent, efficient, cost effective and quality trauma care at all times.
- Participate in trauma patient/family satisfaction projects as developed by hospital.

Performance Improvement:
- Determine and implement PI activities appropriate to the trauma program.
- Oversee the trauma PI program and participate in other quality initiatives that deal with the care of injured patients.
- Review and investigate all trauma PI inquiries in collaboration with the Trauma Program Manager and refer to the appropriate committees.
- Monitor compliance with trauma treatment guidelines, policies and protocols.
- Assure that the quality and appropriateness of patient care are monitored and evaluated and that appropriate actions based on findings are taken on a consistent basis.
- Report quality of care issues promptly to appropriate individuals, including Trauma Program Manager and hospital administration.
- Identify and correct deficiencies in trauma care policies, guidelines and protocols.
- Consult with appropriate medical staff and administration regarding quality care issues and adverse outcomes; identify areas to improve patient care.
- Assure that continuum of care is maintained.
- Identify representatives from various disciplines appropriate to participate in PI activities.
- Coordinate, schedule and facilitate the PI peer review process.
- Review all trauma-related peer review and initiate action as necessary.
- Assist the Trauma Program Manager in evaluating the effectiveness of corrective actions resulting from PI processes.
- Assume responsibility for the accuracy and validity of trauma statistics.

Clinical Education:
- Support the requirements for trauma CME by participating and assisting in the education and training of hospital personnel physicians and specialists.
- Provide education for hospital staff regarding trauma program policies and appropriate medical practices.

Community Outreach:

- Maintain relations with community organization and legislative bodies whose activities relate to trauma care and injury prevention
- Participate in hospital outreach activities as may be requested by administration.
- Develop and participate in trauma community education and injury prevention activities.
- Function as a liaison to other hospitals within the region.

Knowledge and Skill:

- Lead the hospital in program development.
- Analyze and interpret complicated information.
- Determines a course of action based on research, data, standards of care and general guidelines/protocols.
- Communicate effectively with a wide variety of intra- and inter-facility staff and administration using both oral and written communication.
- Possess critical thinking, analytical, teaching/coaching and research skills.
- Maintains the privacy and security of protected health information (PHI), the confidentiality of all information, and conducts all aspects of patient care charting, billing and all operations within the system in a professional and ethical manner in accordance with Federal, State, and HRHS rules and regulations.

Knowledge/Physical Requirements

Knowledge	Occasionally	Frequently	Constantly
Reading Speaking and Writing English			X
Communication Skills			X
Computers			X
Physical			
Walking			X
Bending			X
Standing			X
Sitting			X
Driving			
Lifting up to 50 lbs. with or without assistance			X
Stretching/Reaching			X
Distinguish smell/temperature			X
Hearing/Seeing			X
Exposure to bloodborne			X

pathogens and infectious disease			
Exposure to hazardous material			X
Climbing	X		
Hand/Finger dexterity			X
Stooping (bend at waist)			X
Sensory Activities			
Talking in person			X
Talking on the telephone			X
Hearing in person			X
Hearing on the telephone			X
Vision for close work			X
Other			

OTHER COMPETENCIES

PHYSICAL & ENVIRONMENTAL REQUIREMENTS

The "Risk of Exposure Category" for this job has been identified as a Category 1.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Department of Health

2 North Meridian Street

Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS verification process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital South's efforts to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Our trauma surgeons rotate call to be promptly available twenty-four hours per day. We are committed to responding to "Code Traumas" within thirty minutes of patient arrival. Surgeon response times are continuously evaluated by the Trauma Program Manager and through the hospital's Performance Improvement and Patient Safety program.

I am current with the ATLS certification requirement of the Trauma Medical Director.

Respectfully,

Edward Diekhoff, MD, FACS

Edward Diekhoff, M.D., F.A.C.S.

American College of Surgeons

Division of Education

CONTINUING MEDICAL EDUCATION CERTIFICATE

Edward J. Diekhoff, MD FACS

Has participated in the live activity titled:

Selected Readings in General Surgery
Vol. 39, No. 6: Transfusion and Shock
February 15, 2014

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American College of Surgeons designates this live activity for a maximum of 10.00 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the *AMA PRA Category 1 Credit(s)*™ listed above, a maximum of 10.00 credits meet the requirements for Self-Assessment.

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

Ajit K. Sachdeva, MD, FRCSC, FACS
Director, Division of Education

A. Total *AMA PRA Category 1 Credit(s)*™ claimed: 10.00
B. Of the *AMA PRA Category 1 Credit(s)*™ claimed above, the Self-Assessment credits earned were: 10.00

American College of Surgeons

Division of Education

CONTINUING MEDICAL EDUCATION CERTIFICATE

Edward J. Diekhoff, MD FACS

Has participated in the live activity titled:

Selected Readings in General Surgery
Vol. 40, No. 1: General Oncology, Part I
February 23, 2014

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American College of Surgeons designates this live activity for a maximum of 10.00 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the *AMA PRA Category 1 Credit(s)*™ listed above, a maximum of 10.00 credits meet the requirements for Self-Assessment.

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

Ajit K. Sachdeva, MD, FRCSC, FACS
Director, Division of Education

A. Total *AMA PRA Category 1 Credit(s)*™ claimed: 10.00
B. Of the *AMA PRA Category 1 Credit(s)*™ claimed above, the Self-Assessment credits earned were: 10.00

American College of Surgeons

Division of Education

CONTINUING MEDICAL EDUCATION CERTIFICATE

Edward J. Diekhoff, MD FACS

Has participated in the live activity titled:

Selected Readings in General Surgery
Volume 38, Issue No. 1: Rural Surgery
February 25, 2014

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American College of Surgeons designates this live activity for a maximum of 10.00 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the *AMA PRA Category 1 Credit(s)*™ listed above, a maximum of 10.00 credits meet the requirements for Self-Assessment.

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

Ajit K. Sachdeva, MD, FRCSC, FACS
Director, Division of Education

A. Total *AMA PRA Category 1 Credit(s)*™ claimed: 10.00
B. Of the *AMA PRA Category 1 Credit(s)*™ claimed above, the Self-Assessment credits earned were: 10.00

American College of Surgeons

Division of Education

CONTINUING MEDICAL EDUCATION CERTIFICATE

Edward J. Diekhoff, MD FACS

Has participated in the live activity titled:

Selected Readings in General Surgery
Vol. 39, No. 2: Trauma, Part I
June 29, 2014

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American College of Surgeons designates this live activity for a maximum of 10.00 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the *AMA PRA Category 1 Credit(s)*™ listed above, a maximum of 10.00 credits meet the requirements for Self-Assessment.

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

Ajit K. Sachdeva, MD, FRCSC, FACS
Director, Division of Education

A. Total *AMA PRA Category 1 Credit(s)*™ claimed: 10.00
B. Of the *AMA PRA Category 1 Credit(s)*™ claimed above, the Self-Assessment credits earned were: 10.00

American College of Surgeons

Division of Education

CONTINUING MEDICAL EDUCATION CERTIFICATE

Edward J. Diekhoff, MD FACS

Has participated in the live activity titled:

General Surgery Review Course
OCTOBER 1 - 2, 2012
Chicago, IL

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American College of Surgeons designates this live activity for a maximum of 12.00 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Of the *AMA PRA Category 1 Credit(s)*™ listed above, a maximum of 12.00 credits meet the requirements for Self-Assessment.

AMERICAN COLLEGE OF SURGEONS
Inspiring Quality:
Highest Standards, Better Outcomes

Ajit K. Sachdeva, MD, FRCSC, FACS
Director, Division of Education

A. Total *AMA PRA Category 1 Credit(s)*™ claimed: 12.00
B. Of the *AMA PRA Category 1 Credit(s)*™ claimed above, the Self-Assessment credits earned were: 12.00

Edward Diekhoff, MD

is recognized as having successfully completed the ATLS® Course for Doctors according to the standards established by the ACS Committee on Trauma.

Sharon M. Henry, MD, FACS, Chair	**Kimberly Joseph, MD, FACS**	
Chairperson, ATLS Subcommittee	ACS Chairperson, State/Provincial Committee on Trauma	ATLS Course Director

Date of Issue: 06/07/2014 Date of Expiration: 06/07/2018

Edward Diekhoff, MD

is recognized as having successfully completed the ATLS® Course for Doctors according to the standards established by the ACS Committee on Trauma.

Issue Date:06/07/2014 Expiration Date:06/07/2018

Chairperson, ATLS Subcommittee	ACS Chairperson, State/Provincial Committee on Trauma

CS: 44872-P Course Director ATLS ID:85761

Replacement ATLS cards are available for a $10 USD fee.

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 2

Trauma Program

Manager

2. "**Trauma Program Manager**. This position is usually a registered nurse and must show evidence of educational preparation, with a minimum of 16 hours (internal or external) of trauma – related continuing education per year and clinical experience in the care of the injured patients."

Narrative Response and Discussion

Roxann Kondrat BSN, RN (License #28215068A) is the Community Hospital-South (CHS) Trauma Program Manager. A copy of the job description is attached. Roxann has been an emergency room/ trauma nurse for thirteen years. She has also spent two years in the ICU prior to moving to the Emergency Room and three years in EMS as an EMT. She has worked in multiple trauma centers throughout the United States. She has spent a large portion of her career at Level I trauma center in Columbus, Ohio, were she developed a strong interest in the care of Trauma Patient. While in Columbus, Roxann spent a five and a half years in the ER as a charge nurse and assisted with trauma education and education to incoming residents. In addition, she was a preceptor to incoming new nurses in the department for the Trauma Room. As Roxann's years and knowledge in the emergency room/trauma room grew she was recognized by management as mentor to other nurses in Trauma. Eventually, she was approached by management to become Logan Regional Hospital's Trauma Program coordinator for their level III trauma center. Roxann spent three years as Logan Regional Hospital's Trauma Program Coordinator. In that role, Roxann headed a successful re-certification as a Level III Trauma Center. She also was the lead liaison for the Northern Utah Trauma System Conference that was held annually. The conference draws approximately 300 participants – EMS agencies and Trauma Nurses -- from all over the Intermountain west. While in that role, Roxann finished her BSN and became an instructor for TNCC. Roxann's background includes care of adult and pediatric trauma patients. Roxann has continued to work in the emergency room, keeping current with emergency/trauma care. Roxann is new to the Indianapolis area and is already starting to make connections with other trauma and health care providers to grow the Trauma Program at Community Hospital- South. Resume and certifications and continuing education credits are attached.

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider

American Heart Association.

ROXANN KONDRAT

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.

Issue Date 01/16/2014 — Recommended Renewal Date 01/2016

HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association.

ROXANN KONDRAT

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

Issue Date 03/2013 — Recommended Renewal Date 03/2015

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

American Heart Association
Learn and Live

PALS Provider

ROXANN KONDRAT

This card certifies that the above individual has successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Pediatric Advanced Life Support Program.

Issue Date 01/30/2014 — Recommended Renewal Date 01/2016

CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Organ and Tissue Donations - 2.0 Online Contact Hours

Course Completed: 2014-06-26

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
RN.ORG® Courses are Peer Board Reviewed

For an employee who is a licensed health care practitioner as defined in Florida Statutes 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.

Alzheimer's Disease Course #20-304512 is specifically approved by the Florida Statewide Public Guardianship Office.

RN.ORG®
Calle 28 #No 1-16 Apto 401, Playa Salguero, Rodadero, Santa Marta, Colombia
7816 West Sample Road, Margate, FL 33065
This certificate must be kept for a minimum of 8 years

CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Trauma: Spinal Cord Injuries - 3.0 Online Contact Hours

Course Completed: 2014-06-26

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
RN.ORG® Courses are Peer Board Reviewed

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CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Trauma: Head/Brain Injuries - 3.0 Online Contact Hours

Course Completed: 2014-06-26

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
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This certificate must be kept for a minimum of 8 years

CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Orthopedic Trauma - 2.0 Online Contact Hours

Course Completed: 2014-06-26

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
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This certificate must be kept for a minimum of 8 years

CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Abdominal Trauma - 3.0 Online Contact Hours

Course Completed: 2014-06-26

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
RN.ORG® Courses are Peer Board Reviewed

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CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Burn Care and Management - 1.0 Online Contact Hour

Course Completed: 2014-06-24

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
RN.ORG® Courses are Peer Board Reviewed

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Alzheimer's Disease Course #20-304512 is specifically approved by the Florida Statewide Public Guardianship Office.

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7816 West Sample Road, Margate, FL 33065
This certificate must be kept for a minimum of 8 years

468139

CERTIFICATE OF COMPLETION

Presented to

Roxann Kondrat, RN,

Upon Successful Completion of

Abusive Head Trauma in Children - 2.0 Online Contact Hours

Course Completed: 2014-06-24

Provider approved by
California Board of Registered Nursing, Provider #14777 for Contact Hours
California Department of Public Health #7014
District of Columbia Board of Nursing #50-9351
Florida Board of Nursing #50-9351
West Virginia Board of Registered Professional Nurses WV2006-0503RN
RN.ORG® Courses are Peer Board Reviewed

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This certificate must be kept for a minimum of 8 years

468139

American Trauma Society

American Trauma Society

hereby awards

Roxann Kondrat, RN

this certificate of completion for the
Trauma Coordinator Core Course
Scottsdale, Arizona
November 20-21, 2009

Elizabeth Carlton, Course Director

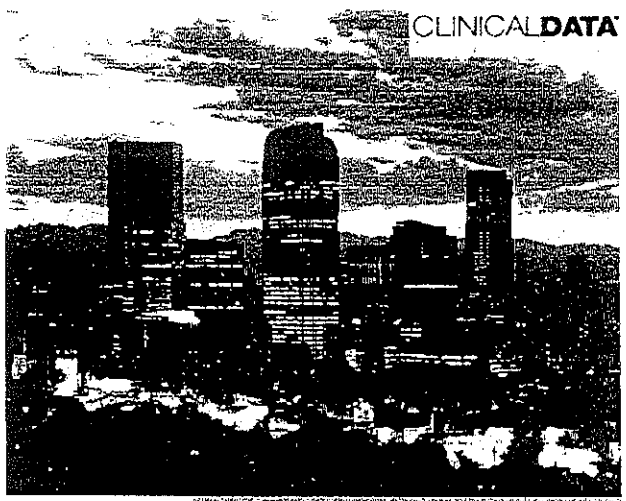
Society for Trauma Nurses is a licensed continuing education provider by the State of California. Provider No. CEP 11062. Course # TCCC17052001. This course has been approved for 15 of hours credit.

CERTIFICATE OF ACHIEVEMENT

ROXANN KONDRAT

This program has been approved for 14 continuing education units for use in fulfilling the continuing education requirements of the American Health Information Management Association (AHIMA).

CLINICALDATA®
MANAGEMENT



CERTIFICATE OF ACHIEVEMENT

Roxann Kondrat

Clinical Data Management, Inc.
2010 Training Conference
Salt Lake City, UT
October 25th & 26th, 2010

2 days-hands on training

*This program has been approved for **14** continuing education unit for use in fulfilling the continuing education requirements of the American Health Information Management Association (AHIMA).*

Intermountain Healthcare

CLINICALDATA® MANAGEMENT

Association for the Advancement of Automotive Medicine

This Certifies that

Roxann Kondrat

has successfully completed the
Injury Scaling: Uses and Techniques Course
Earning a total of 14.08 Continuing Education Contact Hours (ENA)
and 14.0 Continuing Education Credits (AHIMA)

The Emergency Nurses Association (ENA) is an Approver of Continuing Education. ENA's standards meet the required criteria for most State Boards of Nursing. The Emergency Nurses Association is recognized as a provider of continuing education in nursing. Alabama Continuing Education Provider #ABNP0026.
California Continuing Education Provider #CEP2322.
West Virginia Continuing Education Provider #WV2002-0426RN
ENA has approved 14.08 Continuing Education Contact Hours which meets BCEN's Category of Clinical. ENA has approved 0.0 Continuing Education Contact Hours which meets BCEN's Category of Other.

This program has been granted prior approval by the American Health Information Management Association for 14.0 continuing education credit(s). It satisfies the requirements of the Clinical Data Management core educational content area. Granting prior approval in no way constitutes endorsement by AHIMA of the program content or the program sponsor.

Date: **January 12-13, 2009**
Course Number: 090112-IL-C
Location: Salt Lake City, UT

Carl A. Soderstrom, MD
AAAM President

Nursing Profession Advancement Officer – Emergency Nurses Association: Donna Massey, RN, MSN, CCNS
(Do not send this certificate to the Board of Nursing. Keep it for your personal files.
This certificate must be kept by licensee for a period of four years.)

Roxann L. Kondrat

EDUCATION

Western Governors University
Graduated: April 2011
Salt Lake City, Utah
Major Nursing- Bachelor of Science in Nursing

Fox Valley Technical College
Graduated: May 1999
Appleton, Wisconsin
Major: Nursing – Associate Degree

EMPLOYMENT

Florida Hospital-Wesley Chapel, Florida
Emergency Room (November 2012-June 2014)

Responsibilities:
- Staff Nurse (Adult and Pediatric Patients)
- Triage Nurse

St. Joseph Hospital- Tampa, Florida
Level 2 Trauma Center/Emergency Room (October 2011-November 2012)

Responsibilities:
- Staff Nurse (Adult)
- Trauma Room Nurse

Logan Regional Hospital– Logan, Utah
Level 3 Trauma Center Trauma/Stroke Coordinator (November 2008- July 2011)

Responsibilities:
- Ensured that trauma program was in compliance with the American College of Surgeons and State of Utah Guidelines for a Level 3 trauma center
- Headed successful re-certification of Trauma Center (July 2011)
- Established stroke program.
    - Developed protocols and ensured adherence to the State of Utah as a Stroke Receiving Hospital and American Red Cross "Get with the Guidelines" program
- Provided trauma and stroke education to ER/ICU nurses, including the Trauma Nurse Care Course
- Coordinated trauma care and stroke care quality improvement, including collaborating with local and state emergency medical service providers
- Organized the annual Northern Utah Trauma/Stroke Conference, which provided trauma and stoke education to over 250 participants from Utah, Idaho, and Wyoming
- Maintained and Trauma Base database and monitored injury severity scoring of all trauma patents
- Hired and supervised trauma registrars
- Acted as Administrator-on -duty in absence of Emergency Department Manager.
- Handled patient and employee complaints.
- Developed the budget for Trauma Services Department
- Provided education for EMS

Logan Regional Hospital
Emergency Department Registered Nurse (April 2008- July 2011)

Responsibilities

- Triage Nurse
- Staff Nurse/Trauma Nurse Adult and Pediatric patients

Grant Medical Center- Level 1 Trauma Center Emergency Room – Columbus, Ohio
Emergency Room Registered Nurse (September 2002- April 2008)

Responsibilities:

- Triage Nurse
- Trauma Room Nurse:
  - Assisted with patient care and procedure at bedside of major traumas
    - Procedures included: rapid assessment, line placement, neurological assessment, rapid sequence intubation, rapid infuser for fluid and blood products, reduction of bones, DPL, chest tube placements, orthopedic splinting..
- Staff Nurse
- Charge Nurse:
  - Conducted shift briefings
  - Coordinated staff assignments for Nurses, Paramedics, ER physicians, and Physician Assistants
  - Managed patient flow through the department
  - Handled patient and employee complaints/issues
  - Coordinated EMS flow and triage
  - Managed trauma triage from outlying facilities
- Trauma Education
  - Taught Trauma Tactics
  - Provided Monthly education to Trauma Room with new in coming Residents
  - Provided in monthly and yearly trauma education for Nurse and Paramedics
  - trauma education
  - Worked as a preceptor for a new hires, including RNs and Paramedics

St. Mary's Hospital and Medical Center – Madison, WI
Emergency Room Registered Nurse (June 2001- August 2002)

Responsibilities:

- Triage Nurse
- Staff Nurse (Adult and Pediatric)

Stoughton Hospital and Clinics – Stoughton, WI
Intensive Care Unit Registered Nurse (August 1999 – September 2001)

Responsibilities:

- Staff Nurse

- Cross-trained to the Emergency Room, Medical Surgical Unit, Post Anesthesia Recovery Room, Day Surgery and Supportive Care Unit.
- Served on Policy and Procedures, Fall Task force, and Interdepartmental transfer committees.
- Provided care to adult and pediatric patients

Stoughton Area Emergency Medical Service – Stoughton, WI
Paramedic – Basic **(August 1999 – August 2002)**

- Member of a Basic Life Support Ambulance Team

SKILLS

Professional Training

- ACLS Certified
- TNCC Certified and Instructor (re-cert in 06/2014)
- ENPC Certified (re-cert in 6/2014)
- PALS Certified
- Trauma Base and ISS Training
- Trauma Tactics: at Grant Medical Center-Columbus Ohio
- ICU training at St. Mary's Medical Center – Madison, Wisconsin
- EKG training at St. Mary's Medical Center – Madison, Wisconsin
- Twelve Lead EKG interpretation training at St. Mary's Medical Center Madison, Wisconsin

Additional Skills

- Microsoft Office
- Excel
- Trauma Base
- Computer programs in ER (EM-Stat, Cerner First Net, McKesson)

REFERENCES

Dr. Larry Land MD, PhD
Emergency Room Physician
Florida Hospital
[redacted]

Kelley Schaefer, RN,
Emergency Room Nurse
Florida Hospital
[redacted]

Breck Rushton, RN, MPH
Emergency Department Manger
Logan Regional Hospital
[redacted]

Cindy James
Trauma/Stroke Registrar/Emergency Department Unit Clerk
[redacted]

Geoffrey Watson, RN
Ohio State University Hospital
[redacted]

HR USE ONLY

Position Code: 005062
Employee Type: Hourly
Effective Date: 03.17.14
Developed By: ED Department Directors
HR Consultant: S Pearcy

TITLE:	Trauma Program Manager
DEPARTMENT AND COST CENTER:	67803CHN
ROLE OVERVIEW:	The Trauma Program Manager is responsible for the development, implementation and evaluation of systems and programs at Community Hospitals directed toward the provision of quality services for trauma patients from a multidisciplinary perspective throughout the continuum of care. This structure of care for the injured patient is a collaborative effort from all departments that make up the trauma response team.
REQUIRED EXPERIENCE:	Three years clinical experience in the care of injured patients. Previous involvement with trauma certification and data collection.
REQUIRED EDUCATION:	Graduate of an approved nursing program **required,** BSN preferred. **Or** Bachelor's degree with Clinical License (i.e. LPN or Paramedic) w/ 2 years leadership experience & 3 years clinical experience **required.**
REQUIRED LICENSE:	Current Indiana license required (i.e. RN, LPN, Paramedic) Current ACLS certification w/in 6 months TNCC and ATCN w/in 18 months
PREREQUISITE SKILLS:	Educational preparation and clinical experience in the care of injured patients.
SKILLS TESTING:	None
REPORTS TO:	Chief Nursing Officer / Executive Vice President or designee

SUPERVISES: Trauma Registrar

ESSENTIAL FUNCTIONS:

Clinical:

- Assure compliance with the American college of Surgeons and the Indiana State Department of Health standards for the optimal care of the injured patient.
- Help facilitate future strategic goals as a trauma center geared toward excellence and high standards of care.
- Coordinate trauma care management across the continuum of care.
- Coordinate with physicians, nurses and other hospital staff to evaluate and address specific patient care issues.
- Assess the need for policies, procedures, protocols, supplies and equipment relating to the care of trauma patients in coordination with hospital administration and clinicians.
- Develop policies and procedures based on current literature, input from clinicians and other sources, such as information from the trauma peer review process.

Education:

- Provide for intra-facility staff development; participate in case review, implement practice guidelines, and direct community trauma education and prevention programs.
- Performance Improvement:
- Participate in case reviews and trauma rounds.
- Monitor clinical outcomes.
- Monitor system issues related to quality of care delivery.
- Develop quality filters, audits and case reviews.
- Identify trends and sentinel events.
- Assist in the development, implementation and evaluation of a quality plan that is multidisciplinary and focused on patient outcomes.

Administrative:

- Represent the Trauma Program on various hospital and State committees to enhance and foster optimal trauma care management.
- Manage, as appropriate, the operational, personnel and financial aspects of the Trauma Program.
- Supervise adherence to hospital policies, procedures and standards through observation, medical record review, staff feedback and other appropriate sources.
- Trauma Registry:
- Review the collecting, coding, scoring and developing of processes for validation of data entered into the trauma registry.

- Design the registry to facilitate performance improvement activities, trend reports and research, while protecting confidentiality.
- Maintains a minimum of 16 hours of trauma-related continuing education per year and clinical experience in the care of injured patients

EMS/Emergency Management:

- Work with EMS Director and the Audit & Review Committee to review trauma education needs of the EMS agencies.
- Participates on the Hospital Emergency Preparedness Committee and collaborates with District 5 Emergency Preparedness Committee to achieve goals and deliverables.
- Follows through with commitments including employee health requirements, mandatory education and completion of competencies within established timeframes.
- Demonstrates respect for and cooperation with all persons in performing job duties and responsibilities; maintains courteous, complete and confidential communication with all patients, visitors, cooperation-workers and other guests.
- Performs any other tasks, duties or responsibilities as assigned or needed for the effective, safe or efficient functioning/operation of the Hospital.

COMPETENCIES: Hospital / Network mandatory competencies

PHYSICAL/ENVIRONMENTAL REQUIREMENTS: Please see check list

WORK-PLACE ACTIVITIES*

* Frequencies based on DOT (Dictionary of Occupational Titles) standard frequencies

Activity	Never 0% of the day 0 per day 0	Occasional 1-33% of day 1-66 per day 1 per 15 min.	Frequent 34-66% of day 67-200 per day 1 per 5 min.	Constant 67-100% of day 200 plus per day 1 per 30 sec.
Standing		x		
Sitting			x	
Walking		x		
Bending		x		
Forward		x		
Sideways		x		
Climbing		x		
Grasping		x		
Pushing (Carts, wheelchairs, etc)		x		
Pulling (Carts, wheelchairs, etc)		x		
Twisting at waist		x		

Work above shoulders				x				
Repetitive arm movement						x		
Reaching				x				
Overhead:				x				
Forward:				x				
Side:				x				
Rear:				x				
Squatting				x				
Kneeling				x				
Crawling				x				
Wrist & Forearm								
Pronation / Supination						x		
Nondependent patient transfers				x				
Dependent patient transfers				x				
May drive between worksites				x				

Lifting and Carrying		**Never**		**Occasional**		**Frequent**		**Constant**
Under 10 lbs						x		
10-20 lbs				x				
20-30 lbs				x				
30-40 lbs				x				

Role Summary Questionnaire for access to CareConnect

1. Will this role need access to CareConnect (EPIC)? **YES**

   If no, you do not need to answer any other questions.
   If yes, will read-only access be sufficient? **YES**

   If no, please indicate why not:

2. Is there an existing role in the network that is similar to this role? **YES**

If yes, what is that role and what is different with this new role? **Abstractors would be doing the same type of chart review**

3. Will access to view the clients full Social Security Number be necessary? **NO**

   If yes, please explain the reasons:

4. Please indicate the areas in the Network that this employee will be working: **They will need to audit the chart from EMS arrival to Home/Rehab/Death. They will mainly be working through the ED.**

   a. Ambulatory Setting (ie clinic, doctors office, hospital based clinic)
      Please indicate if it will involve any of these activities:

      Front desk **No**
      Billing: physician hospital **No**
      Direct patient care **Review patient chart, no direct patient care**

   b. Inpatient Setting
      Please indicate if it will involve any of these activities:

      Bed planning **No**
      Direct patient care **No**

   c. Surgery
      Please indicate if it will involve any of these activities:

      Scheduling No
      Charging No

   d. Emergency Department - Auditing chart

   e. Radiology
      Please indicate if it will involve any of these activities:

      front desk No

      billing: physician hospital No
      direct patient care No

   f. Home Health Auditing

NOTE: If we need additional details or need a person to review the testing of the Security Template for CareConnect access, whom may we contact? Judy Hall

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 3

Indiana Trauma Registry Submissions

3. "**Submission of trauma data to the state registry**. The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary standard within 30 days of application and at least quarterly thereafter."

Narrative Response and Discussion

The requirements of section 3 are met with a printout illustrating XX admitted trauma patient records reflecting year to date data. This report was generated from the data entered into Imagetrend, the Indiana State Trauma Data Registry.

Audit Report
Created By: Mary Schober
Created On: 06/27/2014

Incident Number	Last Modified Date	Last Modified By
chnchs20140606001	06/15/2014 13:18	Mary Schober
chnchs20140606002	06/15/2014 13:07	Mary Schober
chnchs20140606003	06/15/2014 13:23	Mary Schober
chnchs20140606004	06/15/2014 13:30	Mary Schober
chnchs20140606005	06/15/2014 13:38	Mary Schober
chnchs20140606006	06/15/2014 13:46	Mary Schober
chnchs20140606007	06/15/2014 13:53	Mary Schober
chnchs20140606008	06/15/2014 14:02	Mary Schober
chnchs20140606009	06/15/2014 14:11	Mary Schober
chnchs20140606010	06/15/2014 14:25	Mary Schober
chnchs20140606012	06/15/2014 14:29	Mary Schober
chnchs20140606014	06/15/2014 14:41	Mary Schober
chnchs20140606015	06/15/2014 14:49	Mary Schober
chnchs20140606016	06/15/2014 14:58	Mary Schober
chnchs20140607017	06/15/2014 15:19	Mary Schober
chnchs20140607019	06/15/2014 15:33	Mary Schober
chnchs20140607020	06/15/2014 15:41	Mary Schober
chnchs20140607021	06/15/2014 15:52	Mary Schober
chnchs20140607022	06/15/2014 16:01	Mary Schober
chnchs20140607023	06/15/2014 16:22	Mary Schober
chnchs20140607024	06/15/2014 16:29	Mary Schober
chnchs20140607025	06/15/2014 16:36	Mary Schober
chnchs20140607026	06/15/2014 16:44	Mary Schober
chnchs20140607027	06/20/2014 08:06	Mary Schober
chnchs20140607028	06/20/2014 08:24	Mary Schober
chnchs20140607029	06/20/2014 08:33	Mary Schober
chnchs20140607030	06/20/2014 09:49	Mary Schober
chnchs20140607031	06/20/2014 09:34	Mary Schober
chnchs20140607032	06/20/2014 08:43	Mary Schober
chnchs20140613033	06/13/2014 06:57	Mary Schober
chnchs20140613034	06/13/2014 07:22	Mary Schober
chnchs20140613035	06/13/2014 07:55	Mary Schober
chnchs20140613036	06/13/2014 08:17	Mary Schober
chnchs20140613037	06/13/2014 08:42	Mary Schober
chnchs20140613038	06/13/2014 09:14	Mary Schober
chnchs20140613039	06/13/2014 09:45	Mary Schober
chnchs20140613040	06/13/2014 10:31	Mary Schober
chnchs20140613041	06/13/2014 10:52	Mary Schober
chnchs20140613042	06/13/2014 11:20	Mary Schober
chnchs20140613043	06/13/2014 12:08	Mary Schober
chnchs20140613044	06/13/2014 12:37	Mary Schober
chnchs20140613045	06/13/2014 13:28	Mary Schober
chnchs20140613046	06/13/2014 13:51	Mary Schober
chnchs20140615047	06/15/2014 09:42	Mary Schober
chnchs20140615050	06/15/2014 10:30	Mary Schober
chnchs20140615051	06/15/2014 10:48	Mary Schober
chnchs20140615052	06/15/2014 11:30	Mary Schober
chnchs20140615054	06/15/2014 11:48	Mary Schober
chnchs20140615055	06/15/2014 12:07	Mary Schober
chnchs20140615056	06/15/2014 12:36	Mary Schober

Search Criteria

Dates: From 01/01/2014 To 03/31/2014

Facilities: Community SOUTH Health Network Comm Hosp

Facility Name: Community SOUTH Health Network Comm Hosp

Year: 2014

ıth: April

Number of Records

10

Month: February

Number of Records

16

Month: January

Number of Records

14

Month: June

Number of Records

3

Month: March

Number of Records

20

Month: May

Number of Records

1

Report Criteria

Facility Name: Is Equal To Community SOUTH Health Network Comm Hosp

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 4

Trauma Registrar

4. "**A Trauma Registrar.** This is someone who abstracts high-quality data into the hospital's trauma registry and works directly with the hospital's trauma team. This position is managed by the Trauma Program Manager. "

Narrative Response and Discussion

Community Hospital South has a highly qualified and trained Trauma Registrar. She has several years of experience with Community Health Network and is qualified to abstract high-quality data. The Trauma Registrar reports to the Trauma Program Manager. The Community Health Network Trauma Registrar job description is attached.

Mary C. Schober

QUALIFICATIONS:

- Work well without supervision
- CPR certified
- CNA license
- Ability to prioritize and remain focused on the essence of an issue
- Ability to multi task in stressful situations
- Skilled at learning new concepts quickly while working well under pressure

EXPERIENCE:

8/11-Present ***Community East/South ER department*** Indianapolis, IN

Emergency Department Technician

- Obtains vital signs
- Perform EKG's and bladder scans.
- Obtain blood/urine specimens
- Do POC testing on blood/urine
- Performs accuchecks
- Transports patients to different areas in the hospital
- Cardiac Monitoring
- Secretarial duties in the emergency department (putting orders in, paging MD's etc.)
- OCL splinting on patients when needed.
- Wound care and dressings.
- I/O cath on patients per MD request
- Chart patient care appropriately

04/09-08/11 **IU West Medical Center** Avon, IN

Patient Care Assistant-Med/Surg unit

- Obtain vital signs.
- Perform EKG's and bladders scans
- Perform accuchecks
- Transport patients to different areas of hospital
- Bathed and fed patients when needed.
- Obtained blood/urine specimens
- Assisted RN's in specific tasks when needed
- Charted all patient care appropriately
- Reported any changes in patients to RN

03/06-01/07 **Wishard Health Hospital** Indianapolis, IN

ER Registrar

- Obtained all personal & financial information from patients being seen in ER.
- Data Entry
- Answered multi-line telephone, routed calls, and took accurate messages
- Registered all patients being seen in ER.

10/96-05/01 **St. Francis Hospital** Beech Grove, IN

ER Registrar

- Registered all patients being seen in ER department
- Assigned beds to patients being admitted into hospital
- Updated all log books

09/1994-07/1995 **United States Air Force**

Information Specialist

- Worked at Air War College
- Answered phones and directed them to appropriate personnel
- Typed memo's
- Data Entry

EDUCATION:

Beech Grove High School	**High School Diploma**	**(Aug 89-May 93)**	Beech Grove, IN
Central Nine Education Center	CNA license	(Aug 08-Oct 08)	Greenwood, IN
NurseMed	EMT certification	(Aug 09-Oct 09)	Indianapolis, IN

Current certifications:
CNA license.

Community Health Network

ROLE SUMMARY

TITLE/JOB CODE: Trauma Registrar

DEPARTMENT/COST CENTER: Trauma Program – 67803

REPORTS TO: Trauma Program Manager

DIRECTLY SUPERVISES: None

REVISION DATE: New 2014

ROLE OVERVIEW	The Trauma Registrar is accountable for coordinating the activities for the Trauma Registry. The registrar is responsible for the collection, entry, maintenance, and reporting of data for the Level 3 Trauma Center as required by appropriate regulatory agencies. This position collects trauma data for injury research and prevention as well as performance improvement in the Trauma Program within the facility. This position acts as a liaison with the Trauma Program Manager, Medical Directors, and trauma staff. The Trauma Registrar will assist in the preparation for the American College of Surgeons Committee on Trauma site visit and other regulatory agency visits such as ISDOH and JCAHO.
REQUIRED EXPERIENCE	Trauma experience preferred. Preferred knowledge of ICD-9/10; CPT; DRG; AIS and ISS coding. Knowledge of database management and proficiency in Microsoft Office applications.
REQUIRED EDUCATION	A Credentialed Emergency Medical Technician; Emergency Department Technician or licensed Paramedic; Certified Coding Specialist; Registered Health Information Technician; Registered Health Information Administrator, or Registered Record Administrator.
REQUIRED LICENSE CERTIFICATIONS	Must attend Trauma Registry and ICD-10 training within 6 months of employment. Certified Trauma Registrar within 2 years of employment.
PRE-REQUISITE SKILLS	Requires knowledge of database management and proficiency in Microsoft Office applications. Requires knowledge and proficiency in medical and hospital terminology. Requires the ability to communicate clearly and concisely through written

and verbal communication.
Requires strong customer service skills.
Requires the ability to manage multiple tasks.
Requires the ability to utilize critical thinking skills to prioritize and problem-solve complex work assignments.

ESSENTIAL FUNCTIONS

Administration:

- Collects and enters data into the trauma registry regarding trauma patients at the Trauma Center in a timely manner.
- Collaborates with Information Technology computer hardware and software maintenance and backup to assure proper registry function.
- Assigns and scores all injuries utilizing the AIS and ICD-9/10 scoring system. Completes and verifies for accuracy all data collected.
- Evaluates the documentation of nursing staff/hospital providers and identifies missing data elements. Coordinates with nursing administration to correct and obtain the information on the hospital record. Reconciles the data as the information becomes available.
- Ensures compliance with National Trauma Data Bank (NTDB) and Indiana Department of Public Health (ISDH) required standards.
- Creates reports and spreadsheets as required and exports or imports data into reports.
- Participates as an integral member of the Trauma Quality Improvement team. Involved in leadership and professional development to assure skills and knowledge of trauma information.
- Evaluates current trends in injury mechanism and advises administrative team regarding needs for Prevention Initiatives.
- Cognitively reviews data and advises on needs for change in the Trauma Center Plan.
- Compiles and analyzes administrative reports for regulatory agencies, participating institutions, and committees as directed by the Trauma Medical Director or Trauma Program Manager.
- Works with the Trauma Program Manager collaborating as an advisor for development of the hospital multidisciplinary team.

Research:

- Actively participates in educational and clinical research projects conducted by the Trauma Medical Director.
- Analyzes data and conducts research relating to education, prevention, and/or trauma services.

Service/Teaching:

- Prepares data and trends for presentation at national, state, and local meetings.
- Education of nursing staff with regards to required trauma documentation and requirements to maintain the policies and procedures as laid out in the Trauma Center Plan.
- Represents the trauma center at national, state, and local meetings, as requested by the Trauma Medical Director.
- Serves on local, state, and national committees as requested by the

Trauma Program Manager.

- Works collaboratively with physicians, coworkers, management and other departments.
- Completes mandatory 4 hours of registry specific training per year in addition to other continuing education and contact education requirements mandated for licensure and certification.

Knowledge/Physical Requirements

Knowledge	Occasionally	Frequently	Constantly
Reading Speaking and Writing English			X
Communication Skills			X
Computers			X
Physical			
Walking			X
Bending			X
Standing			X
Sitting			X
Driving			
Lifting up to 50 lbs. with or without assistance			X
Stretching/Reaching			X
Distinguish smell/temperature			X
Hearing/Seeing			X
Exposure to bloodborne pathogens and infectious disease			X
Exposure to hazardous material			X
Climbing	X		
Hand/Finger dexterity			X
Stooping (bend at waist)			X
Sensory Activities			
Talking in person			X
Talking on the telephone			X
Hearing in person			X
Hearing on the telephone			X
Vision for close work			X
Other			

OTHER COMPETENCIES

PHYSICAL & ENVIRONMENTAL REQUIREMENTS

The "Risk of Exposure Category" for this job has been identified as a Category 1.

The American Trauma Society

Hereby Awards

Mary Schober

this certificate for successful completion of the

Trauma Registrar
Distance Learning Course

This activity has been approved for 10 CME Contact Hours
Code Number: LA10-3-1104-11-4
The Maryland Nurses Association (MNA)
The MNA is an accredited approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation

Ian Weston
Executive Director

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 5

Tiered Activation System

5. "**Tiered Activation System.** There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program."

Narrative Response and Discussion

The requirements of section 5 are met with an attached copy of the Community Health Network Tiered Activation System Guideline. The Community Hospital South PIPS team continuously evaluates the compliance and effectiveness of the Tiered Activation System Guideline.

Community Health Network

7330 Shadeland Station
Indianapolis, IN 46256
317-621-6262
eCommunity.com

Emergency Department Tiered Activation Guideline

Purpose:

1. To provide criteria for a tiered trauma activation system
2. To establish a systematic approach to the delivery of care of the trauma patient.
3. To provide expedient assessment, treatment of life threatening injuries, stabilization, and/or transport to a higher level of care.

General Information:

1. To clearly define the roles of individuals involved in the care of trauma patients.
2. To define the level of trauma care and response to such levels.

Personnel:

Applicable to staff of the Emergency Department, Administrative Representative, Registration, Switchboard, Laboratory, Radiology, Respiratory Services, Spiritual Care, and the Trauma Surgeon on call.

Equipment: Trauma Room and medical supplies to care for the patient.
Portable x-ray machine and CT scanner.
Ultrasound for ED Physician and Trauma Surgeon use.

Procedure:

1. Team Members
    a. Availability of personnel will depend upon level of staffing and may require initiation of on call systems.
        1. Emergency Department (ED) Physicians
        2. Trauma Surgeon
        3. Emergency Department (ED) Nurse(s)
        4. Emergency Department (ED) Charge Nurse
        5. Administrative Representative
        6. Emergency Department (ED) Tech(s)
        7. Respiratory Therapist
        8. Radiology/CT Technologist
        9. Registration/Patient Access

    b. Additional Department Notifications
        1. ICU (as needed)
        2. Operating Room Staff and Anesthesiologist (as needed)
        3. Laboratory/Blood bank
        4. Chaplain (as needed)
        5. Security
2. Levels of Trauma
    a. **Code Trauma: (paged out to team):**
        1. Systolic B/P <90 mm Hg
        2. Glasgow Coma Scale (GCS) < or =13
        3. Respiratory rate <10 or >29
        4. Patients receiving blood to maintain vital signs

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5. Airway or respiratory compromise as defined by:
    1. BVM, intubation, adjunct airway or cricothyroidotomy in the field
    2. Needle chest decompression
6. Penetrating injury to head, neck, chest, abdomen, back, buttocks, or extremities proximal to the knees and elbows
7. Traumatic amputation proximal to the wrist or ankle
8. Burns >15% or high voltage (>1000volts) electrical injury
9. Any crushed, de-gloved, mangled, or pulseless extremity
10. Pelvic fracture
11. Two or more long bone fractures
12. Flail chest
13. Extremity paralysis suggestive of spinal cord injury
14. Open or depressed skull fracture
15. Victim of hanging who meet above criteria
16. Licensed healthcare provider discretion

b. Trauma alert (not paged out to team):

1. Ejection from vehicle
2. Vehicle roll-over
3. Death in same vehicle
4. Prolonged extrication from vehicle
5. Pedestrian struck by vehicle
6. Falls >20 feet (adults) or >3X the child's height
7. Licensed Healthcare provider discretion

3. Levels of Response
    a. Code Trauma
        1. Upon notification from the ED physician or ED RN, the ED staff will notify the switchboard operator by telephone to initiate the Code Trauma page. The switchboard operator will initiate an alpha-numeric page to the trauma team members defined above.
        2. ED staff will record times team members were paged, time trauma surgeon responded to call, and time trauma surgeon arrived to hospital.
        3. All trauma team members report to the Emergency Department upon paging. The trauma surgeon will initially respond via phone.
    b. Trauma Alert
        1. Upon notification from the ED physician or ED Nurse, the ED staff will notify the Administrative Representative, the Respiratory Therapist and the Radiology/CT Technologist by telephone or other appropriate in-house communication.
        2. There will be no alpha-numeric paging regarding trauma alerts. The ED staff will record all relevant times.
        3. The Radiology/CT Technologist will report to the ED and all other trauma team members are "on-call" at their original location pending further notification.

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Code Trauma Role Definition Summary Guideline

Purpose: To clearly define the roles of individuals involved in the care of trauma patients.

1. Code Trauma Team Member Role Definitions
    a. Emergency Department Physician
        1. Corresponds with pre-hospital personnel or ED staff taking report to determine level of trauma prior to patient arrival.
        2. Assumes overall coordination of trauma room activities until a trauma surgeon or specialist surgeon arrives to assume care or patient has been transferred to a higher level Trauma Center
        3. Responsible for patient assessment and to perform life-saving interventions for life-threatening injuries found on primary survey.
    b. Trauma Surgeon
        1. Responds to the Code Trauma patient and is available in the Emergency Department within 30 minutes of the patient's arrival.
        2. Responsible for the overall care of the trauma patient.
        3. Coordinates care with other specialties to facilitate continuity of care.
        4. Evaluates and treats the patient.
        5. Participates in the initial evaluation and resuscitation of the seriously injured patients.
    c. Emergency Department Nurse
        1. Performs primary and secondary assessment of trauma patient upon arrival to Emergency Department, assuring priority of care and initiation of resuscitation protocols.
        2. Responsible for overall coordination of care delivered by nursing and ancillary personnel.
        3. Responsible for adequately stocking the Trauma Room and making sure all equipment is in functioning order.
        4. Re-assesses and evaluates patient response to interventions.
        5. Responsible for documentation, observation, delegation, and communication of care of the trauma patient:
            a. Documentation
                1. Completion of Trauma Critical Care Record.
                2. Completion of all transfer records when applicable.
            b. Observation
                1. Knowledge of patient status at all times.
                2. Monitors vital functions.
                3. Assures that personnel are functioning in proper capacity for protocol and job description.

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c. Delegation
    1. Assures proper patient care by delegation of orders and/or procedures to appropriate personnel.

d. Communication
    1. Assures communication of patient report to receiving unit or hospital.
    2. Assures patient update reports to the Emergency Department physician and/or trauma surgeon.

d. Emergency Department Charge Nurse
    1. Assigns trauma staff as required.
    2. Takes pre-hospital report when Emergency Department physician is not available.
    3. Follows guidelines to make level of trauma determination when ED physician is not available.
    4. Is present upon patient arrival to Emergency Department until stabilized.
    5. Acts as a resource for trauma team.
    6. Performs interventions for trauma patient care when needed.
    7. Coordinates continuation of care for existing patients in department

e. Emergency Department Tech
    1. Is present upon patient arrival to Emergency Department.
    2. Performs tasks delegated by ED Trauma Nurse (i.e.: assists with hemorrhage control, wound care, CPR, immobilization, spine stabilization, Foley insertion, procedure set-up).

f. Respiratory Therapist
    1. Team members will respond as assigned to both Code Trauma and Trauma Alert.
    2. Maintain an open airway.
    3. Assist with intubation or cricothyrotomy.
    4. Maintain positive pressure ventilation.
    5. May obtain ABG's as delegated.
    6. Accompany patient to other areas if airway management and/or ventilation required.

g. Radiology Technologist
    1. Team members will respond as assigned.
    2. Obtains images as ordered
    3. All portable images must be completed prior to patient going to CT scan unless otherwise directed by either the Emergency Department physician or the trauma surgeon.
    4. Will promptly prepare CD copies of all imaging studies in preparation for emergency transfer to a Level 1 facility.

h. CT Scan Technologist

1. Upon receiving the page, will finish with any current scans and clear scanner until trauma scans are finished.
2. Initiate call to the Radiologist as required.

i. Laboratory/Blood Bank
   1. Prepares cooler containing two (2) units O negative blood and emergency transfusion documents. Responds to Emergency Department with blood when specifically called.
   2. Collects necessary blood specimens and properly bands patient
   3. Notifies Emergency Department when type-specific and cross-matched blood is available.

j. Registration
   1. Makes chart and places Identification (ID) band on patient. Merges anonymous male/female trauma patient as soon as identification made.
   2. Gives ED staff identification labels as soon as possible.

k. Unit Secretary/Emergency Department Staff
   1. Obtains Code Trauma form, and tracks communication times with physicians.
   2. Performs initial notifications as described in 3a and 3b above.
   3. Coordinates phone calls for consultants, inter-facility transfers and transportation as directed.

l. Chaplain
   1. Minister to patient and family members as necessary.
   2. Notify family members as necessary.
   3. Keep family updated on patient care.

m. Security
   1. Crowd control as necessary.
   2. Secures perimeter of Emergency Department and hospital for any potential dangerous activity.

n. Additional Department Notifications
   1. ICU as needed.
   2. Operating Room Staff and Anesthesiologist as needed.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 17, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Department of Health

2 North Meridian Street

Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS verification process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital South's efforts to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Our trauma surgeons rotate call to be promptly available twenty-four hours per day. We are committed to responding to "Code Traumas" within thirty minutes of patient arrival. Surgeon response times are continuously evaluated by the Trauma Program Manager and through the hospital's Performance Improvement and Patient Safety program.

I am current with the ATLS certification requirement of the Trauma Medical Director.

Edward Diekhoff MD, FACS

Respectfully,

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

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JK-05130

June

General Surgical Care South On-call Schedule as of 5/21/2014

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
1 DIEKHOFF	**2** CLARK	**3** DIEKHOFF	**4** BOWLDS	**5** CLARK	**6** O'NEIL	**7** O'NEIL
8 O'NEIL	**9** CLARK	**10** O'NEIL	**11** BOWLDS	**12** O'NEIL	**13** CLARK	**14** CLARK
15 CLARK	**16** DIEKHOFF	**17** BOWLDS	**18** CLARK	**19** DIEKHOFF	**20** BOWLDS	**21** BOWLDS
22 BOWLDS	**23** O'NEIL	**24** DIEKHOFF	**25** CLARK	**26** BOWLDS	**27** DIEKHOFF	**28** DIEKHOFF
29 DIEKHOFF	**30** O'NEIL					**Dr. O'Neil is unavailable 6/14/14 thru 6/22/14 & 6/26/14 thru 6/29/14**

2014

May

General Surgical Care South On-call Schedule

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
Dr. Diekhoff is unavailable 4/17/14 thru 5/04/14 & 5/17/14 thru 5/18/14	**Dr. Clark is unavailable 5/02/14 thru 5/08/14**	**Dr. Bowlds is unavailable 5/03/14 thru 5/04/14 & 5/17/14 thru 5/18/14**	**Dr. O'Neil is unavailable 5/10/14 thru 5/11/14**	1 CLARK	2 O'NEIL	3 O'NEIL
4 O'NEIL	5 BOWLDS	6 O'NEIL	7 BOWLDS	8 O'NEIL	9 BOWLDS	10 BOWLDS
11 BOWLDS	12 CLARK	13 O'NEIL	14 CLARK	15 BOWLDS	16 O'NEIL	17 O'NEIL
18 O'NEIL	19 CLARK	20 DIEKHOFF	21 BOWLDS	22 DIEKHOFF	23 CLARK	24 CLARK
25 CLARK	26 CLARK Memorial Day	27 DIEKHOFF	28 BOWLDS	29 CLARK	30 DIEKHOFF	31 DIEKHOFF

2014

April

General Surgical Care South On-call Schedule as of 04/28/13

Sun	*Mon*	*Tue*	*Wed*	*Thu*	*Fri*	*Sat*
Dr. O'Neil is unavailable 3/28/14 thru 4/6/14	**Dr. Bowlds is unavailable 3/31/14 thru 4/6/14**	1 CLARK	2 DIEKHOFF	3 CLARK	4 DIEKHOFF	5 DIEKHOFF
6 DIEKHOFF	7 CLARK	8 DIEKHOFF	9 BOWLDS	10 O'NEIL	11 BOWLDS	12 BOWLDS
13 BOWLDS	14 DIEKHOFF	15 O'NEIL	16 DIEKHOFF	17 CLARK	18 O'NEIL	19 O'NEIL
20 O'NEIL	21 BOWLDS	22 O'NEIL	23 BOWLDS	24 O'NEIL	25 CLARK	26 CLARK
27 CLARK	28 O'NEIL	29 BOWLDS	30 **BOWLDS**	**Dr. Diekhoff is unavailable 4/17/14 thru 5/04/14**	**Dr. Clark is unavailable 4/11/14 & 4/23/14**	

2014

Trauma Surgeon response Log for "Code Trauma's "

CHS 2014

Date	*Patient MRN*	*Time of patient arrival*	*Time of Trauma Surgeon arrival*	*Total Minutes to response*	*Trauma Surgeon*
01/01/2014	00012564	0323	0340	17min.	Diekhoff

Community
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eCommunity.com

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner

Indiana State Trauma Care Committee

Indiana State Department of Health

2 North Meridian Street

Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center Designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that Dr. Diekhoff, our Trauma Medical Director, is a member of the Community Hospital South Emergency Management Committee.

Respectfully,

Elisa Stott

Elisa Stott
Network Emergency Preparedness
Coordinator and Safety Manager

Edward Diekhoff MD, FACS

Edward Diekhoff, M.D., F.A.C.S
Trauma Medical Director

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 7

Emergency Department Physician Coverage

7. "**In-house Emergency Department physician coverage.** The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients."

Narrative Response and Discussion

The requirements of section 7 are met with a signed letter from Dr. Joel Parker. Dr. Parker is the Chief Medical Director for Indiana Emergency Solutions at Community Hospital South. The letter affirms that there is twenty – four hour in-house coverage of emergency physicians to care for injured patietns.

Community
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June 16, 2014

William C. VanNess II, M.D., - Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

Indiana Emergency Solutions a division of EmCare provides physician coverage to the Emergency Department at Community Hospital South. IES currently has 18 physicians credentialed on staff at Community Hospital South who ensure the immediate care of all sick and injured patients in our emergency department. All physicians on staff are board certified or board eligible in a specialty recognized by the American Board of Medical Specialties.

I am the Chief Medical Director for the Emergency Department at Community Hospital South. As the Director, I ensure that the standards of quality and efficiency are maintained by the ED physicians on a daily basis.

Respectfully,

Joel Parker, M.D.
Chief Medical Director
Indiana Emergency Solutions

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Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227

Released: 02/03/14 5:39 pm

YSICIAN: MARCH 2014

Revised: 02/04/14 9:46 am

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1 D - A SANDERS M - TAKESUE E - BENCE N - WOODALL
2 D - E PARKER M - TAKESUE E - BENCE N - WOODALL	3 D - BENEDICT M - E PARKER E - DWYER N - BENCE	4 D - J PARKER M - A SANDERS E - WOODALL N - KOPCZYNSKI	5 D - J PARKER M - A SANDERS E - DWYER N - KOPCZYNSKI	6 D - B. BLACK M - BENEDICT E - BENCE N - KOPCZYNSKI	7 D - E PARKER M - J PARKER E - HELMS N - KOPCZYNSKI	8 D - MURPHY M - TAKESUE E - MOZES N - HELMS
9 D - BENEDICT M - STUCKWISCH E - MOZES N - KOPCZYNSKI	10 D - BENCE M - BENEDICT E - DWYER N - KOPCZYNSKI	11 D - HELMS M - MOZES E - WOODALL N - DWYER	12 D - HELMS M - A SANDERS E - WOODALL N - E PARKER	13 D - B. BLACK M - A SANDERS E - BENCE N - KOPCZYNSKI	14 D - WOODALL M - E PARKER E - BENCE N - KOPCZYNSKI	15 D - WOODALL M - TAKESUE E - BENCE N - KOPCZYNSKI
D - WOODALL M - TAKESUE E - DWYER N - KOPCZYNSKI	17 D - WOODALL M - MOZES E - E PARKER N - DWYER	18 D - BENEDICT M - E PARKER E - HELMS N - DWYER	19 D - BENCE M - J PARKER E - E PARKER N - HELMS	20 D - WOODALL M - MOZES E - DWYER N - HELMS	21 D - BENCE M - A SANDERS E - DWYER N - KOPCZYNSKI	22 D - J PARKER M - BENCE E - HELMS N - KOPCZYNSKI
23 D - DWYER M - BENCE E - HELMS N - KOPCZYNSKI	24 D - DWYER M - HELMS E - WOODALL N - KOPCZYNSKI	25 D - E PARKER M - MOZES E - WOODALL N - KOPCZYNSKI	26 D - J PARKER M - HELMS E - DWYER N - KOPCZYNSKI	27 D - B. BLACK M - HELMS E - E PARKER N - BENCE	28 D - MOZES M - WOODALL E - E PARKER N - BENCE	29 D - HELMS M - STUCKWISCH E - E PARKER N - KOPCZYNSKI
30 D - J PARKER M - STUCKWISCH E - DWYER N - WOODALL	31 D - J PARKER M - BENCE E - BENEDICT N - WOODALL					

Day: 6AM-2PM
MID: 11AM-9PM
Eve: 2PM-12AM
Night: 9PM-6AM

For any scheduling changes, please contact:
Nick Ragsdale

Scheduler - Nick Ragsdale Ragsdale

* = Pending Privileges

For after regular business hours emergenices, contact Answering Service at

DO NOT CALL NICK DIRECTLY.

Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227-

Released: 03/04/14 9:47 am

IYSICIAN: APRIL 2014

Revised: 03/04/14 9:47 am

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 D - * EPPLER M - BENCE E - MOZES N - KOPCZYNSKI	2 D - * EPPLER M - BENCE E - WOODALL N - KOPCZYNSKI	3 D - * EPPLER M - WOODALL E - BENEDICT N - KOPCZYNSKI	4 D - E PARKER M - J PARKER E - BENCE N - KOPCZYNSKI	5 D - HELMS M - A SANDERS E - STUCKWISCH N - E PARKER
6 D - HELMS M - DWYER E - STUCKWISCH N - BENCE	7 D - WOODALL M - A SANDERS E - HELMS N - BENCE	8 D - J PARKER M - E PARKER E - A SANDERS N - DWYER	9 D - WOODALL M - E PARKER E - BENCE N - HELMS	10 D - WOODALL M - A SANDERS E - DWYER N - HELMS	11 D - WOODALL M - BENEDICT E - DWYER N - KOPCZYNSKI	12 D - J PARKER M - E PARKER E - TAKESUE N - DWYER
13 D - * EPPLER M - STUCKWISCH E - TAKESUE N - WOODALL	14 D - MOZES M - A SANDERS E - DWYER N - E PARKER	15 D - BENEDICT M - A SANDERS E - DWYER N - WOODALL	16 D - HELMS M - J PARKER E - E PARKER N - KOPCZYNSKI	17 D - DWYER M - BENCE E - WOODALL N - KOPCZYNSKI	18 D - HELMS M - BENCE E - BENEDICT N - KOPCZYNSKI	19 D - A SANDERS M - WOODALL E - B. BLACK N - KOPCZYNSKI
20 D - TAKESUE M - MOZES E - B. BLACK N - KOPCZYNSKI	21 D - BENEDICT M - J PARKER E - E PARKER N - KOPCZYNSKI	22 D - B. BLACK M - DWYER E - HELMS N - KOPCZYNSKI	23 D - WOODALL M - HELMS E - E PARKER N - MOZES	24 D - DWYER M - WOODALL E - E PARKER N - HELMS	25 D - DWYER M - E PARKER E - MOZES N - WOODALL	26 D - BENCE M - DWYER E - TAKESUE N - KOPCZYNSKI
27 D - BENCE M - STUCKWISCH E - TAKESUE N - KOPCZYNSKI	28 D - E PARKER M - WOODALL E - BENCE N - DWYER	29 D - E PARKER M - J PARKER E - A SANDERS N - BENCE	30 D - MOZES M - A SANDERS E - DWYER N - HELMS			
		Day: 6AM-2PM **MID: 11AM-9PM** **Eve: 2PM-12AM** **Night: 9PM-6AM**		For any scheduling changes, please contact: Nick Ragsdale Scheduler - Nick Ragsdale Ragsdale		

* = Pending Privileges

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Indianapolis, IN 46227-

Released: 04/04/14 9:18 am

YSICIAN: MAY 2014

Revised: 04/15/14 3:10 pm

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1 D - MOZES M - DWYER E - WOODALL N - HELMS	2 D - BENCE M - J PARKER E - E PARKER N - WOODALL	3 D - A SANDERS M - J PARKER E - E PARKER N - BENCE
4 D - DWYER M - J PARKER E - MOZES N - BENCE	5 D - BENEDICT M - E PARKER E - HELMS N - DWYER	6 D - WOODALL M - J PARKER E - HELMS N - DWYER	7 D - STUCKWISCH M - J PARKER E - E PARKER N - KOPCZYNSKI	8 D - A SANDERS M - HELMS E - BENEDICT N - KOPCZYNSKI	9 D - MOZES M - A SANDERS E - E PARKER N - KOPCZYNSKI	10 D - WOODALL M - MOZES E - TAKESUE N - KOPCZYNSKI
11 D - BENCE M - WOODALL E - TAKESUE N - KOPCZYNSKI	12 D - DWYER M - BENEDICT E - BENCE N - E PARKER	13 D - HELMS M - WOODALL E - A SANDERS N - KOPCZYNSKI	14 D - HELMS M - WOODALL E - DWYER N - KOPCZYNSKI	15 D - MULVEY M - A SANDERS E - BENCE N - KOPCZYNSKI	16 D - STUCKWISCH M - HELMS E - DWYER N - BENCE	17 D - * EPPLER M - HELMS E - BENEDICT N - MOZES
18 D - * EPPLER M - HELMS E - TAKESUE N - KOPCZYNSKI	19 D - J PARKER M - E PARKER E - DWYER N - KOPCZYNSKI	20 D - BENCE M - BENEDICT E - A SANDERS N - KOPCZYNSKI	21 D - E PARKER M - J PARKER E - A SANDERS N - HELMS	22 D - MOZES M - DWYER E - * * * OPEN * * * N - HELMS	23 D - E PARKER M - DWYER E - BENCE N - MOZES	24 D - B. BLACK M - DWYER E - TAKESUE N - E PARKER
25 D - J PARKER M - DWYER E - TAKESUE N - KOPCZYNSKI	26 D - A SANDERS 6:00A-6:00P M - STUCKWISCH 11:00A-11:00P N - KOPCZYNSKI 6:00P-6:00A	27 D - BENEDICT M - J PARKER E - DWYER N - MOZES	28 D - E PARKER M - HELMS E - B. BLACK N - KOPCZYNSKI	29 D - * EPPLER M - BENCE E - B. BLACK N - DWYER	30 D - J PARKER M - BENCE E - HELMS N - KOPCZYNSKI	31 D - J PARKER M - STUCKWISCH E - E PARKER N - KOPCZYNSKI
		Day: 6AM-2PM **MID: 11AM-9PM** **Eve: 2PM-11PM** **Night: 9PM-6AM**		For any scheduling changes, please contact: Nick Ragsdale Scheduler - Nick Ragsdale Ragsdale		

* = Pending Privileges

For after regular business hours emergenices, contact Answering Service : DO NOT CALL NICK DIRECTLY.

Community Hospital South - ED
1402 E. County Line Road
Indianapolis, IN 46227-

Released: 05/05/14 3:41 pm

IYSICIAN: JUNE 2014

Revised: 05/06/14 10:48 am

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 D - J PARKER M - STUCKWISCH E - B. BLACK N - DWYER	2 D - BENEDICT M - COY E - MOZES N - DWYER	3 D - J PARKER M - COY E - BENEDICT N - KOPCZYNSKI	4 D - HELMS M - COY E - J PARKER N - KOPCZYNSKI	5 D - HELMS M - BENEDICT E - COY N - BENCE	6 D - HELMS M - J PARKER E - MOZES N - BENCE	7 D - A SANDERS M - TAKESUE E - HELMS N - MOZES
8 D - J PARKER M - TAKESUE E - BENEDICT N - MOZES	9 D - DWYER M - A SANDERS E - BENCE N - HELMS	10 D - J PARKER M - DWYER E - A SANDERS N - KOPCZYNSKI	11 D - MOZES M - DWYER E - A SANDERS N - KOPCZYNSKI	12 D - BENCE M - DWYER E - HELMS N - KOPCZYNSKI	13 D - J PARKER M - BENEDICT E - MOZES N - HELMS	14 D - J PARKER M - STUCKWISCH E - BENCE N - MOZES
15 D - DWYER M - STUCKWISCH E - BARKER N - KOPCZYNSKI	16 D - J PARKER M - DWYER E - BARKER N - KOPCZYNSKI	17 D - J PARKER M - BENEDICT E - BENCE N - KOPCZYNSKI	18 D - A SANDERS M - J PARKER E - BENCE N - KOPCZYNSKI	19 D - COY M - A SANDERS E - DWYER N - IRWIN II	20 D - BENCE M - A SANDERS E - DWYER N - IRWIN II	21 D - BENCE M - TAKESUE E - DWYER N - KOPCZYNSKI
D - BENCE M - TAKESUE E - DWYER N - KOPCZYNSKI	23 D - A SANDERS M - HELMS E - J PARKER N - KOPCZYNSKI	24 D - EPPLER M - HELMS E - B. BLACK N - DWYER	25 D - EPPLER M - BENEDICT E - HELMS N - DWYER	26 D - BENCE M - BARKER E - HELMS N - DWYER	27 D - J PARKER M - A SANDERS E - BENCE N - KOPCZYNSKI	28 D - J PARKER M - STUCKWISCH E - HELMS N - KOPCZYNSKI
29 D - J PARKER M - STUCKWISCH E - HELMS N - KOPCZYNSKI	30 D - DWYER M - BENCE E - HELMS N - KOPCZYNSKI					

Day: 6AM-2PM
MID: 11AM-9PM
Eve: 2PM-11PM
Night: 9PM-6AM

For any scheduling changes, please contact:
Nick Ragsdale

Scheduler - Nick Ragsdale Ragsdale

Recruiter - John Magombo

* = Pending Privileges

For after regular business hours emergenices, contact Answering Service at

DO NOT CALL NICK DIRECTLY.

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Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 8

Orthopedic Surgery

8. "**Orthopedic Surgery.** There must be an orthopedic surgeon on call and promptly available 24 hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement."

Narrative Response and Discussion

The requirements of section 8 are met with a signed letter of commitment from Dr. Kevin Julian, M.D., Orthopedic Surgeon liaison to the Community Hospital South PIPS committee. This letter affirms that Community Hospital South has orthopedic surgeons promptly available twenty – four hours per day.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I am the orthopedic surgery liaison to the Trauma Performance Improvement and Patient Safety (PIPS) committee. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Two orthopedic groups, Greenwood Orthopedics, Ortho Indy, and Dr. MacInstosh provide orthopedic surgeon on – call to Community Hospital South. An orthopedic surgeon is promptly available 24 hours per day. The surgeon on call is provided to the Emergency Department staff one month in advance with any changes being communicated via email.

Respectfully,

Kevin Julian, M.D.
Orthopedic Surgery
Chief of Medical Staff

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

Cor unity Hospital South Call Schedule for ril 2014

April 2014

April 2014

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 2014

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Mar 30 - Apr 5	**Mar 30**	**31**	**Apr 1** OI Lavery	**2** Jackson	**3** OI Lavery	**4** OI Justice	**5** OI Dilella
Apr 6 - 12	**6** OI Dilella	**7** McIntosh	**8** OI Justice	**9** Jackson	**10** Martin	**11** Julian	**12** Julian
Apr 13 - 19	**13** Julian	**14** Martin	**15** Jackson	**16** Julian	**17** OI Justice	**18** McIntosh	**19** McIntosh
Apr 20 - 26	**20** McIntosh	**21** OI Justice	**22** Martin	**23** OI Lavery	**24** OI Justice	**25** OI Falender	**26** OI Falender
Apr 27 - May 3	**27** OI Falender	**28** Jackson	**29** OI Lavery	**30** Martin	**May 1**	**2**	**3**

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Community Hospital South Call Schedule for May 2014

May 2014

May 2014

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 2014

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Apr 27 - May 3	Apr 27	28	29	30	May 1 McIntosh	2 O.I. Falender	3 O.I. Falender
May 4 - 10	4 O.I. Lavery	5 McIntosh	6 Martin	7 Jackson	8 O.I. Lavery	9 Julian	10 Julian
May 11 - 17	11 Julian	12 O.I. Justice	13 Julian	14 McIntosh	15 O.I. Lavery	16 Jackson	17 Jackson
May 18 - 24	18 Jackson	19 O.I. Woo	20 O.I. Dilella	21 McIntosh	22 O.I. Falender	23 Martin	24 Martin
May 25 - 31	25 Martin	26 O.I. Dilella	27 O.I. Justice	28 O.I. Dilella	29 O.I. Justice	30 O.I. Lavery	31 O.I. Lavery

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Community Hospital South Call Schedule for June 2014 DRX 05/30

June 2014

June 2014

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July 2014

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Jun 1 - 7	Jun 1 O.I. Lavery	2 Julian	3 Martin	4 Martin	5 Julian	6 McIntosh	7 McIntosh
Jun 8 - 14	8 McIntosh	9 Martin	10 Jackson	11 Martin	12 O.I. Falender	13 O.I. Justice	14 O.I. Justice
Jun 15 - 21	15 O.I. Justice	16 Jackson	17 O.I. Lavery	18 Jackson	19 McIntosh	20 O.I. Dilella	21 O.I. Dilella
Jun 22 - 28	22 O.I. Falender	23 Julian	24 Jackson	25 O.I. Lavery	26 Julian	27 O.I. Justice	28 O.I. Justice
Jun 29 - Jul 5	29 O.I. Justice	30 O.I. Dilella	Jul 1	2	3	4	5

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 9

Neurosurgery

9. "**Neurosurgery.** The hospital must have a plan that determines which type of neurologic injuries should remain at the facility for treatment and which types of injuries should be transferred out for a higher level of care. This plan must be agreed upon by the neurosurgical surgeon and the facility's Trauma Medical Director. There must be a transfer agreement in place with Level I or Level II trauma centers for the hospital's neurosurgical patient population. The documentation must include a signed letter of commitment by neurosurgeons and the Trauma Medical Director."

Narrative Response and Discussion

The requirements of section 9 are met with a signed letter of commitment and a neurosurgery plan for trauma patients from Community Health Network's Chief of Neurosurgery the Trauma Medical Director of Community Hospital South. There is a transfer agreement in place with Eskenazi Health and IU Health for adult neurosurgery patients. Community Health Network Neurosurgeons provide coverage twenty-four hours per day.

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Community
Health Network

June 16, 2014

William C. VanNess II, M.D. -- Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as the Chief of Neurosurgery for Community Health Network. I am pleased to support Community Health Network's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

The Neurosurgeons at Community Health Network are committed to providing care for patients with traumatic injury. I further understand that we have transfer agreements in place to accept trauma patient transfers determined to be beyond our scope by our Neurosurgery plan for trauma patients.

Respectfully,

John T. Cummings Jr., M.D.
Chief of Neurosurgery

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

Community Health Network

Neurosurgery Plan for Trauma Patients

The following list of injuries with known or suspected neurological involvement will be considered for rapid transfer to a Level I trauma center if a Community Health Network Neurosurgeon and appropriate resources are not available.

- Penetrating injury/open fracture with or without cerebrospinal fluid leak
- Intra-cranial hemorrhage
- Depressed skull fracture
- GCS <11 or deteriorating mental status or lateralizing neurological signs
- Spinal cord injury or major vertebral injury
- Carotid or vertebral arterial injury

Respectfully,

John T. Cummings, Jr. M.D.
Chief of Neurosurgeon

Edward Diekhoff, M.D., F.A.C.S.
Trauma Medical Director

CHE / CHN NEUROSURGEON ON CALL 4pm-7 am

April 2014

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
	31	1 Hall	2 Donaldson	3 Kim	4 Rendel	5 Rendel 24 Hr Coverage
6 Rendel 24 Hr Coverage	7 Sloan	8 Cummings	9 Rendel	10 Sloan	11 Donaldson	12 Donaldson 24 Hr Coverage
13 Donaldson 24 Hr Coverage	14 Hall	15 Sloan	16 Cummings	17 Rendel	18 Kim	19 Kim 24 Hr Coverage
20 Kim 24 Hr Coverage	21 Hall	22 Donaldson	23 Hall	24 Sloan	25 Cummings	26 Cummings 24 Hr Coverage
27 Cummings 24 Hr Coverage	28 Sloan	29 Kim	30 Hall			

Dr. Cummings - Pager
Dr. Sloan - Pager
Dr. Donaldson - Pager
Dr Hall - Pager
Dr. Rendel - Pager
Dr. Kim - Pager

NIGHT CALL

**Weekends and Holidays are 24 hour coverage unless noted.

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CHE / CHN NEUROSURGEON ON CALL 4pm - 7am

May 2014

Please call during office hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1 Rendel	2 Kim	3 Kim 24 Hour Coverage
4 Kim 24 Hour Coverage	5 Donaldson	6 Hall	7 Donaldson	8 Cummings	9 Hall Dr. Donaldson PTO	10 Hall 24 Hour Coverage
11 Hall 24 Hour Coverage	12 Sloan	13 Donaldson	14 Sloan	15 Cummings DCH & RBS Mtg.	16 Rendel DCH & RBS Mtg.	17 Rendel 24 Hour Coverage
18 Rendel 24 Hour Coverage	19 Hall	20 Cummings	21 Donaldson	22 Kim	23 Sloan JTC & JWD PTO	24 Sloan 24 Hour Coverage
25 Sloan 24 Hour Coverage	26 Rendel Memorial Day 24 Hour Coverage	27 Sloan	28 Donaldson	29 Kim	30 Cummings	31 Cummings 24 Hour Coverage

Dr. Cummings - Pager
Dr. Sloan - Pager
Dr. Donaldson - Pager
Dr Hall - Pager
Dr. Rendel - Pager
Dr. Kim - Pager

**Weekends & Holidays are 24 hour coverage

NIGHT CALL

CHE / CHN/CHS NEUROSURGEON ON CALL 4pm-7 am

June 2014

TLK 6/10

Please call the office at during regular office hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					30 Cummings	31 Cummings 24 Hour Coverage
1 Cummings 24 Hour Coverage	2 Donaldson	3 Rendel	4 Sloan	5 Cummings	6 Kim	7 Kim 24 Hour Coverage
8 Kim 24 Hour Coverage	9 Hall	10 Sloan	11 Cummings	12 Rendel	13 Sloan	14 Sloan 24 Hour Coverage
15 Sloan 24 Hour Coverage	16 Hall	17 Cummings	18 Kim	19 Hall	20 Rendel	21 Rendel 24 Hour Coverage
22 Rendel 24 Hour Coverage	23 Donaldson	24 Cummings	25 Sloan	26 Kim	27 Donaldson	28 Donaldson 24 Hour Coverage
29 Donaldson	30 Sloan					

Dr. Cummings - Pager
Dr. Sloan - Pager
Dr. Donaldson - Pager
Dr Hall - Pager
Dr. Rendel - Pager
Dr. Kim - Pager

**Weekend and Holiday Call is 24 Hour Coverage

NIGHT CALL

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 10

Transfer Criteria
And Agreements

10. "**Transfer agreements and criteria.** The hospital must include as a part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals."

Narrative Response and Discussion

The requirements of section 10 are met with a copy of the Community Health Network Trauma Transfer Guidelines and trauma transfer agreements with adult and pediatric Level I trauma centers.

Community Health Network has established a relationship with Eskenazi Health as our trauma mentor hospital. In addition to opportunities for education and performance improvement there is a signed transfer agreement that covers adult trauma patients including neurological and burn care.

Also enclosed is a signed transfer agreement with IU Health. This agreement covers the transfer of adult and pediatric patients. Riley provides neurosurgical and burn care to pediatric patients.

Community Health Network

Trauma Transfer Guidelines

- The on call Trauma Surgeon or Emergency Department physician will decide which patients are to be transferred to a higher level of care.
- The injuries listed below are strongly recommended by the American College of Surgeons to be transferred to a level I or level II designated center.
  - ✓ Carotid or vertebral arterial injury
  - ✓ Torn thoracic aorta or great vessel
  - ✓ Cardiac rupture
  - ✓ Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
  - ✓ Major abdominal vascular injury
  - ✓ Grade IV or V liver injuries requiring >6 U RBC transfusion in 6 hours
  - ✓ Unstable pelvic fracture requiring > 6 U RBC transfusion in 6 hours
  - ✓ Fracture or dislocation with loss of distal pulses
  - ✓ Penetrating injury or open fracture of the skull
  - ✓ Glassgow Coma Scale < 14 or lateralizing neurologic signs
  - ✓ > 2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
  - ✓ Open long bone fracture
  - ✓ Significant torso injury with advanced comorbid disease
- The on call trauma Surgeon or Emergency Department physician will call for all patients being transferred to Eskenazi and will be connected directly to Eskenazi's on call trauma surgeon.
- For patients being transferred to IU Health the Surgeon or Emergency Department physician will call the IU Health 24/7 Transfer Center at
- The Surgeon or Emergency Department physician will decide if the patient travels via ground or aeromedical transportation with the most appropriate level of care (ALS, BLS).
- There will not be any delay in transfer due to laboratory or diagnostic testing that does not have any impact on the resuscitation of the patient.
- The transferring RN will complete the transfer checklist.
- The transferring RN will call report to the receiving facility.
- The transferring RN will complete the transfer form (electronic and paper).
- The transferring RN will accompany the patient when deemed necessary by the Surgeon or Emergency Department physician.

TITLE: EMTALA: EMERGENCY MEDICAL SCREENING, STABILIZATION AND TRANSFER

Background and Purpose: This policy outlines the responsibilities of the Community Health Network hospitals (Hospitals) under the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985, primarily in response to concern that some emergency departments across the country had refused to treat indigent and uninsured patients or had inappropriately transferred them to other hospitals, a practice known as "patient dumping." EMTALA requires hospitals that participate in Medicare to provide a medical screening examination to any person who comes to the emergency department, regardless of the individual's ability to pay. If a hospital determines that the person has an emergency medical condition, it must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility. Along with these primary responsibilities, EMTALA also places additional, related responsibilities on participating hospitals.

Policy:

1. Definitions. The following words or terms used in this policy have the definitions given below:
    a. "Capacity" means the ability of the Hospital to accommodate the individual requesting examination or treatment of the transferred individual. "Capacity" includes such things as numbers and availability of qualified staff, beds and equipment, and the Hospital's past practices of accommodating additional patients in excess of its occupancy limits.
    b. "Comes to the emergency department" means the individual:
        i. Has presented at the Hospital's emergency department (ED) and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. A "request" for examination or treatment under this policy will be considered to have occurred if, based upon the individual's appearance or behavior, a prudent layperson observer would believe that the individual needs examination or treatment for a medical condition;
        ii. Has presented on Hospital property (other than the ED) and requests examination or treatment for what may be an emergency medical condition;
        iii. Is in a ground or air ambulance owned and operated by the Hospital, even if the ambulance is not on Hospital property, unless (1) the ambulance is operated under community-wide EMS protocols that direct it to transport the individual to another hospital; or (2) the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the Hospital;
        iv. Is in a ground or air ambulance NOT owned by the Hospital, but is on Hospital property for examination and treatment for a medical condition at the Hospital's ED. This is true even if Hospital personnel correctly informed EMS personnel of the Hospital being on official diversionary status and the EMS personnel disregarded that information and brought the individual onto Hospital property anyway[1].
    c. "Dedicated emergency department" (DED) means any department or facility of the Hospital, whether on or off the main campus of the Hospital, that
        i. Is licensed by the State as an emergency department;

[1] If the Hospital is officially on diversionary status and EMS personnel contact the Hospital by radio or phone to transport an individual, Hospital personnel may direct the ambulance to another facility. However, if the ambulance comes to the Hospital anyway, the Hospital now has an EMTALA obligation to the individual being transported.

ii. Holds itself out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment (this includes the Network's Family Rooms, Behavioral Health Pavilion, and MedChecks); or
iii. Has provided at least one-third of its outpatient services in the last calendar year on an urgent basis without requiring prior appointments.

d. "Emergency Medical Condition" or (EMC) means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms or substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:
   i. Placing the health of the individual (or with respect to a pregnant woman, placing the health of the woman or the unborn child) in serious jeopardy;
   ii. Serious impairment to bodily functions; or
   iii. Serious dysfunction of any bodily organ or part.

   With respect to a pregnant woman who is having contractions:
   i. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
   ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

e. "Hospital property" means the entire main Hospital campus (defined as the physical area immediately adjacent to the main hospital buildings and other hospital areas and structures that are within 250 yards of the main buildings), including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the Hospital's main building that are not part of the Hospital, such as physician offices or non-medical facilities.

f. "Labor" means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.

g. "Stabilize" means, with respect to an emergency medical condition, to provide medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to occur during the transfer of the individual from a facility or that the woman has delivered the child and the placenta.

h. "Transfer" means the movement (including the discharge) of an individual outside the Hospital's facilities at the direction of any person employed by, affiliated or associated, directly or indirectly, with the Hospital.

2. Hospital Responsibilities Under EMTALA. All hospitals with a dedicated emergency department, must provide an appropriate medical screening examination for any individual who comes to the emergency department to determine whether an emergency medical condition exists. If an emergency medical condition is determined to exist, the Hospital must provide any necessary stabilizing treatment and/or an appropriate transfer.

   The Hospital's EMTALA obligation is also triggered if an individual comes elsewhere on Hospital property (that is, other than the ED) and either requests examination and treatment for an EMC or appears to be, from the perspective of a prudent layperson, suffering from an EMC. For all areas outside of the ED on Hospital property, if a health care professional or other individual is not available or unable to escort/transport the individual to the ED, 911 should be called. 911 responders can provide treatment and/or transfer the individual to the ED. Exception: For an individual experiencing cardiopulmonary arrest within the hospital or

certain other designated areas as set forth in the Cardiopulmonary Resuscitation Policy (CLN #2005), the Code Blue Team should be summoned.

EMTALA does NOT apply to Hospital inpatients or to registered outpatients who have begun to receive a scheduled course of outpatient care. However, other policies of CHNw and laws and regulations apply to inpatients and registered outpatients that must be followed.

a. Medical Screening Examination. The Hospital must provide an appropriate medical screening examination (MSE). An "appropriate MSE" is
   i. An exam that is performed within the capability of the Hospital's emergency department, including any ancillary services routinely available to the ED (i.e., x-ray, lab services, etc.), to determine if an emergency medical condition exists or not;
   ii. The ongoing process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist;
   iii. Reflected in the medical record with continued monitoring according to the patient's needs until he/she is stabilized or appropriately transferred; and
   iv. Is the same MSE that the Hospital would perform on any individual coming to the ED with the same signs and symptoms, regardless of the individual's ability to pay for medical care.

At CHNw, individuals that are qualified to perform an MSE at a Hospital are members of the Hospital's medical staff (physician, resident or allied health professional members) with the appropriate clinical privileges, or the employees designated in this Policy. Specifically, those individuals who may perform the MSE are as follows:

i. General medical screening exams: Emergency department physicians; emergency department allied health professionals; and other physician, resident or allied health professional members of the medical staff with appropriate clinical privileges.
ii. MSEs on pregnant women:
   1. Emergency department physicians; emergency department allied health professionals; other physician, resident or allied health professional members of the medical staff with appropriate clinical privileges; or registered obstetrical nurses with required competencies.
   2. A pregnant woman having contractions will be considered to be in true labor unless a physician certifies, after a reasonable time of observation, that the woman is in false labor. This may be done directly by the physician or by the physician in telephone consultation with another provider performing the exam. Certification done by telephone consultation must be documented as a physician's order and countersigned by the physician within 24 hours.
iii. MSEs for mental health issues:
   1. Those individuals presenting to ED may receive the MSE by emergency department physicians; emergency department allied health professionals; other physician, resident or allied health professional members of the medical staff with appropriate clinical privileges; or licensed Behavioral Health Services clinical staff in consultation with a physician.

2. Those individuals presenting to the Behavioral Health Pavilion may receive the MSE by licensed Crisis Department clinical staff in consultation with a physician, or by a physician or allied health professional member of the medical staff with appropriate clinical privileges.

b. Stabilizing Treatment. If it is determined that the individual has an EMC, the Hospital, within the capabilities of the staff and facilities at the Hospital, must provide the treatment required to stabilize the individual's medical condition.

c. Delays in Examination or Treatment.
   i. A medical screening examination or treatment for an emergency medical condition may not delayed in order to inquire about the individual's method of payment or insurance status.
   ii. Delays in the MSE or stabilizing treatment may not occur in order to obtain pre-certification or authorization for reimbursement or treatment from any third party payer, HMO, PPO, or primary medical provider.

      i. However, reasonable registration processes may occur, including inquiring about insurance, as long as the registration process does not delay examination/treatment or unduly discourage individuals from remaining for further evaluation.
      ii. Refusing to take over an individual's care from EMS providers who have brought the individual to the Hospital DOES NOT delay or rid the Hospital of its obligations to the individual under EMTALA. This is true even if the Hospital is officially on diversionary status. Remember, once an individual is on Hospital property and has requested, or reasonably appears to be in need of, a medical screening exam for a medical condition, the Hospital's EMTALA obligations have been triggered.
      iii. A minor child can request examination or treatment for an EMC. Delay in examination or treatment the MSE by waiting for parental consent should not occur. If, after screening the minor, it is determined that no EMC is present, it is permissible to wait for parental consent before proceeding with further examination and treatment.

d. Restricting Transfer Until Stabilized. If an individual has an EMC and has not been stabilized, the individual will not be transferred unless:
   i. An "appropriate transfer" (defined below) is made;
   ii. The individual (or a legally responsible person acting on the individual's behalf) requests the transfer after being informed of the Hospital's obligations under EMTALA and the risks of transfer. This request must be in writing and must indicate that he or she is aware of the risks and benefits of the transfer; or
   iii. A physician certifies that the medical benefits reasonably expected from the provision of medical treatment at another facility outweigh the risks to the individual or, in the case of a pregnant woman, to the woman or the unborn child, from being transferred. If a physician is not physically present, a qualified medical person must make the transfer in consultation with the physician. The certification must be documented on the Transfer Form and

the physician must countersign the certification. All certifications must contain a summary of the risks and benefits to the individual.

e. Perform an "Appropriate Transfer". An appropriate transfer under EMTALA is one in which: (Utilize transfer form N556-0702 ESI# 10377)
   i. The Hospital provides medical treatment within its capacity that minimizes the risk to the individual's health, or the woman and unborn baby's health;
   ii. Is made to a facility that has available space and qualified personnel for the individual's treatment and has agreed to the transfer and to provide the appropriate medical treatment;
   iii. The Hospital sends copies of all medical records related to the presenting EMC that are available at the time of the transfer to the receiving facility, and copies of any other records not available at the time of the transfer to the receiving facility as soon a possible after the transfer;
   iv. The transfer is made through qualified personnel and transportation equipment, as required, including the use of appropriate life support measures during the transfer; and
   v. Communications to the receiving hospital are appropriate, i.e., physician to physician, nurse to nurse, therapist to therapist.

f. Responsibilities as a Recipient Hospital: If the Hospital has specialized capabilities or facilities such as neo-natal intensive care units or shock-trauma units, it may not refuse a transfer of an individual who is in need of such specialized care, as long as it has the capacity to treat the individual.

g. At Community Hospitals:
   i. A private physician may only accept a transfer as a direct admit when previous arrangements have been made by the private physician with the admitting office and only if a bed is available.

   ii. A private physician may accept transfer of an unstable patient for specialized care that is not available at the sending hospital, if the sending physician certifies that the benefits outweigh the risk. Ideally the patient is sent directly to the point of care; however, the patient may be sent to the ED if a bed is not available. For unstable patients being sent to the ED, there must be communication between the private physician and the emergency department physician.

   iii. When a potential EMTALA violation is identified, a Confidential Peer Review Report must be completed and forwarded to Quality Resources within 24 hours. (See CLN-2006, Confidential Peer Review Reports, Sentinel Events and Medical Error/ Adverse Outcomes Disclosure).

3. Limited Exceptions to EMTALA Obligations. In addition to EMTALA not applying to inpatients or to a registered outpatient who has begun a course of outpatient treatment, EMTALA does not apply, or the Hospital is considered to have met its obligations under EMTALA, if:
   a. After an MSE, the individual refuses further examination and stabilizing medical treatment. A description of the examination and/or treatment that was refused by the individual (or refused on his or her behalf) must be documented in the medical record. In addition, Hospital personnel must take all reasonable steps to get the individual to sign a written refusal which includes a statement of the risks and benefits of the examination and/or treatment.

b. The individual does not consent to an appropriate transfer after being informed of the risks and benefits of such a transfer. A description of the proposed transfer must be documented in the medical record and Hospital personnel must take all reasonable steps to get the refusal to consent (including risks and benefits associated with the transfer) in writing. If the individual refuses to consent to the transfer, he or she will be treated within the capabilities of the Hospital and Hospital personnel.
c. The Centers for Medicare and Medicaid Services issues an advisory notice that in response to a declared emergency or disaster and a declared public health emergency, that it is waiving sanctions for the redirection of individuals seeking MSEs when a state emergency preparedness plan or pandemic preparedness plan has been activated in the Hospital's area, or for inappropriate transfers arising out of the circumstances of the emergency. Hospital personnel will NOT implement changes under this section unless specifically instructed to by Hospital Administration.

4. Other Responsibilities Under EMTALA. In addition to the primary obligations listed above, the Hospitals also have other responsibilities under EMTALA.
   a. Signage.
      i. The Hospital must post signs conspicuously in the ED or in other places likely to be notices by all individuals entering the ED, as well as by individuals waiting for examination and treatment in other areas, such as entrances, admitting areas, waiting rooms and treatment areas.

      ii. These signs must (1) specify the rights individuals have with respect to examination and treatment for emergency medical conditions and labor under EMTALA; and (2) indicate that the Hospital participates in the Medicaid program.
      iii. The wording of the signs must be clear, simple and in languages that are understandable by the population served by the Hospital.

   b. Central Log: CHNw Process
      i. The Hospital must maintain a central log on each individual who comes to the ED seeking assistance and indicate in the log whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred or discharged.
      ii. Departments may use computerized or manual logs as long as all required information is captured and easily retrievable.
      iii. Logs must be maintained is such a manner as to prevent unauthorized persons from viewing patient information.
      iv. All logs must be kept in a central location in each department and be retained for at least 7 years.

   c. On-call Physicians: CHNw Process
      The Hospital must maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.
      i. The individual physician's name and not the group name must be on the schedule.
      ii. The request for contact with any on-call physician shall be made by or at the direction of the ED/attending physician or Crisis therapist.

iii. The on-call physician, if requested, is obligated to come on site within 60 minutes to provide further examination and/or stabilizing treatment.
iv. If there is a disagreement between the ED/attending physician and the on-call specialist regarding the patient's care, the physician who is on-site providing direct care makes the final decision.
v. If an on-call physician fails to respond by ED/attending physician will contact the department chairperson for the appropriate specialty who will secure immediate coverage. A Confidential Peer Review Report must be completed.
vi. If the on-call physician's refusal or delay in treatment of the patient results in the transfer of the patient, the physician's name and address must be documented on the Transfer Form in order to comply with EMTALA. In addition, a Confidential Peer Review Report must be completed.

References:
Federal Regulations: 42 United States Code 1395dd; aka Section 1867 of Social Security Act, aka Section 1921 of Consolidated Omnibus Reconciliation Act of 1985; revised 1997; revised 1999; revised 2000; revised 2005

The EMTALA Answer Book; 2005 Edition, Moy, Mark M.: Aspen Publishers, 2005

Practice Management "EMTALA final Rule," Issued September 9, 2003, effective November 10, 2003. Prepared by the American Medical Association (AMA)

Emergency Department Compliance and Reimbursement Insider 2000

42 U.S.C § 1395dd (Examination and Treatment for Emergency Medical Conditions and Women in Labor.

State Operations Manual, Appendix V-Interpretive Guidelines. Responsibilities of Medicare Participating Hospitals in Emergency Cases. (Rev. 1, 05-21-04).

42 C.F.R. § 489.20 (2007).
73 FR 48433 (8/19/08).
68 FR 53222 (9/9/03).

Formulated by: Quality Resources
Legal Counsel

Approved by:	Quality Resources	Date:	05/12
	Legal Counsel	Date:	04/12
	Medical Staff Office	Date:	12/08
	Infection Prevention	Date:	05/12
	TIHH	Date:	5/12
Approved:	CNO Designee	Date:	05/12
Approved:	_____ Chief Operations Officer	Date:	_____

GENERAL TRANSFER CHECKLIST TOOL

- ☐ 1. Obtain physician/off site designee certification. **(NOT REQUIRED FOR PATIENT REQUEST)**
- ☐ 2. Obtain patient consent. (If patient refuses – **STOP! PATIENT DOES NOT TRANSFER.**)
- ☐ 3. Complete transfer form.
- ☐ 4. Verify, that physician/off site designee has documented risks and benefits of transfer in patient record.

- ☐ 5. Verify that physician/off site designee has contacted receiving physician, who accepts patient. Document on chart and on transfer form.

- ☐ 6. Verify receiving facility has available space and personnel and call report. Document on transfer form.

- ☐ 7. Call for appropriate mode of transportation. Document on transfer form.

- ☐ 8. Recheck vital signs immediately before transfer. Document on transfer form

- ☐ 9. For in-house, document names of all on-call physicians and consult/arrival times.

- ☐ 10. Send copies of all medical records:
  - Nursing documentation, 100%
  - Physician documentation, 100%
  - Consent
  - Transfer Form
  - X-Rays
  - Lab results
  - Other diagnostic results
  - Document in chart

- ☐ 11. For in-house, if the physician refused to care for patient:
  - Complete Transfer Form – *Physician Care Unavailable Only*
  - Call the following and document on the transfer form:
    Chief, refusing MD's department
    Chief, Medical Staff
    Administrator on-call

  - Also call:
    Risk Management within 24 hours
    Department Clinical Director or designee on-call
  - Document name and address of refusing/unavailable MD on transfer form
  - Complete Confidential Peer Review and turn in to Clinical Director

Make additional copies of this form as needed

This form is NOT part of patient medical record.

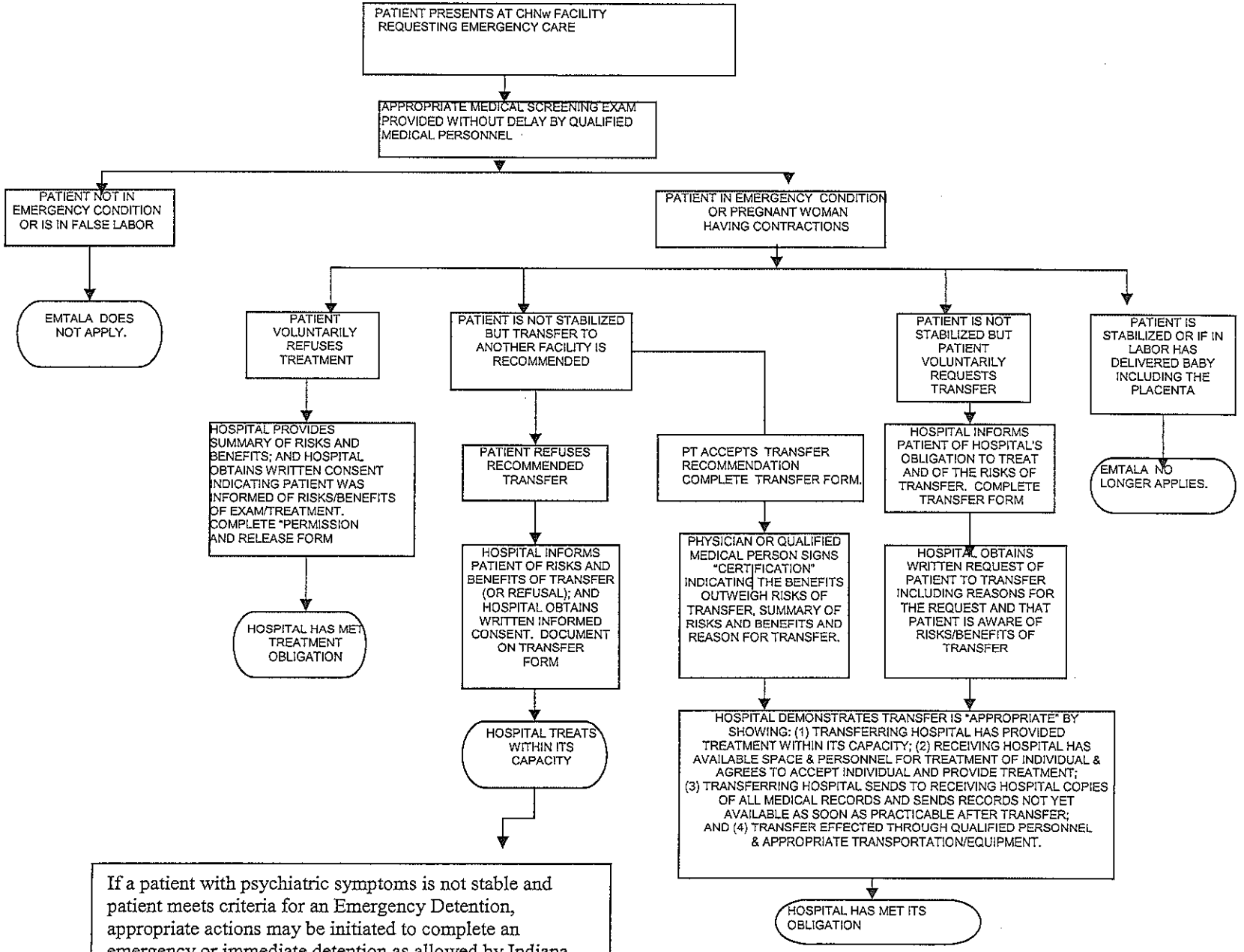
BEHAVORIAL Health SERVICES/CRISIS INTERVENTION
TRANSFER CHECKLIST TOOL

- ☐ 1. Obtain physician certification. **(NOT REQUIRED FOR PATIENT REQUEST)**
- ☐ 2. Obtain patient consent. (If patient refuses – **STOP! PATIENT DOES NOT TRANSFER.**)
- ☐ 3. Complete transfer form.
- ☐ 4. Verify, obtained by physician consult, that the documented risks and benefits of transfer on the transfer form.
- ☐ 5. Verify that Crisis has contacted receiving physician, or Crisis team, who accepts patient. Document on chart and on transfer form.
- ☐ 6. Verify receiving facility has available space and personnel and call report. Document on transfer form.
- ☐ 7. Call for appropriate mode of transportation. Document on transfer form.
- ☐ 8. Recheck vital signs immediately before transfer, if patient in Emergency Room. Document on transfer form
- ☐ 9. Document names of all on-call physicians and consult/arrival times.
- ☐ 10. Send copies of all medical records:
  - Crisis documentation (Universal Assessment Form; Medical Questionnaire; Any information pertinent to current situation E.g., copies of previous crisis notes, progress notes, detentions, etc.)
  - If obtained, copy of release of information to receiving facility.
  - Consent
  - Transfer Form
  - Nursing documentation, 100%, if being sent form ER.
  - Physician documentation, 100%, if being sent from ER.
  - X-Rays, if being sent from ER.
  - Lab results, if being sent from ER.
  - Other diagnostic results, if being sent from ER.
- ☐ Document in chart, what specific information was sent.

11. If the physician refused to care for patient:
  - Complete Transfer Form – *Physician Care Unavailable Only*
  - Call the following and document on the transfer form:
    Chief unavailable MD's department
    Chief, Medical Staff
    Administrator on-call
  - Also call:
    Risk Management within 24 hours
    Department Clinical Director or designee on-call
  - Document name and address of refusing/unavailable MD on transfer form
  - Complete Confidential Peer Review and turn in to Clinical Director

Make additional copies of this form as needed

COMMUNITY HOSPITALS INDIANAPOLIS
MEDICAL SCREENING AND TRANSFER PROCESS



If a patient with psychiatric symptoms is not stable and patient meets criteria for an Emergency Detention, appropriate actions may be initiated to complete an emergency or immediate detention as allowed by Indiana law, and transported to BH Pavilion for further evaluation and possible admission.

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VII. EMTALA Monthly Audit Process

A. Each CHNw Emergency Department will conduct its own monthly EMTALA audits using the attached spreadsheet.

B. Minimum of five Transfer audits to be completed monthly.

C. Instructions for Spreadsheet:

Transfer paperwork completed

a. To obtain a 1 = yes
   i. A transfer form must be completed and signed by patient or family member; or patient not competent to sign checked.
   ii. Corresponding transfer certification completed and signed by transferring physician or patient initiated request for transfer signed (no certification required by MD).
   iii. Documentation portion of form completed
      1. RN to RN contact
      2. Mode of travel
      3. Copies of paperwork
      4. Vital signs before transfer

b. To obtain a 0 = no
   i. Any one thing from above not completed results in an incomplete transfer form.

2. Condition of Patient
   a. Triage category listed
      i. Emergent
      ii. Urgent
      iii. Non-urgent
3. Medical Screening Exam (MSE) Performed
   a. Yes or No
4. On-call time and response time documented
   a. Yes or No
5. On-call response time documented
   a. Yes or No
6. Peer review form completed if no response to on-call
   a. Yes or No
7. Condition stated after MSE
   a. Yes or No
8. Registered Nurse
   a. Name of RN on transfer from
9. Comments

D. If a negative trend is discovered during the EMTALA audits, then an additional ten audits will be done for that month to see if a pattern develops (i.e.: particular RN or MD) and then counsel as appropriate.

#	MR #	DOS	Transfer Paperwork Complete	Condition of Patient	Medical Screening Exam (MSE) Performed (yes/no)	Timeliness Documented	On-Call, Call Time and Response Time Documented	On-Call Response Documented	Peer Review Form Complete if no response	Condition Stated AFTER MSE	RN	Comments
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												
15												
16												
17												
18												
19												
20												
	Total Records Reviewed		0		0	0	0	0	0	0		
	# Correct		0		0	0	0	0	0	0		
	# of Errors		0		0	0	0	0	0	0		
	Error Rate		#DIV/0!		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		

NS=Not Stated	1=Yes	E=Emergent	1=Yes	1=Yes	1=Yes	1=Yes	1=Yes	1=Yes
n/a=not applicable	0=No	U=Urgent N=Non-urgent	0=No	0=No	0=No	0=No	0=No	0=No

Transfer paperwork completed

A. To obtain a 1 = yes

1. A transfer form must be completed and signed by patient or family member; or patient not competent to sign checked
2. Corresponding transfer certification completed and signed by transferring physician or patient initiated request for transfer signed (no certification required by MD)
3. Documentation portion of form completed
   a. RN to RN contact
   b. Mode of travel
   c. Copies of paperwork
   d. Vital signs before transfer

B. To obtain a 0 = no

Any one thing from above not completed results in an incomplete transfer form

Condition of Patient

Triage category - emergent, urgent, and non-urgent

Medical Screening Exam (MSE) Performed

Yes or No

Timeliness Documented

??What are we considering timely? Is this timeliness of MD in performing MSE??

On-Call Time and Response Time Documented

ED MD's document times referring or attending MD called/paged.

On-Call Response Time Documented

Yes or No

Peer Review form Completed if No Response to On-Call

Yes or No

Condition Stated After MSE

Yes or No

RN

Name of RN on transfer form

Comments

What ever you like.

COMMUNITY PHYSICIAN NETWORK – COMMUNITY PHYSICIANS OF INDIANA
PREPARATION/APPROVAL PROCESS FOR SERVICE CONTRACTS

TYPE OF CONTRACT: Service Agreement – Transfer Agreement
CONTRACTOR: IU Health Hospitals

INITIATION/PREPARATION:

Originator: Ron Lewis
Department: Neurology
Location: 7330 Shadeland Station
Telephone:
Responsibility for Drafting:
Outside Party ____ Legal X

A. LEGAL
Reviewed: ____ Approved: ____
By: Template Date: ____

RETURN TO Cathy Leonard AFTER EACH APPROVAL STEP

B. CONTRACT SUMMARY

COST $ N/A Hr./Mo./Yr. Ea.

TERM: June 1 20 14 to
*May 31 20 15

PURPOSE & DETAILS:
Renews annually in successive one-year terms
Transfer agreement between CHNw and IU Health, which includes IU Methodist, Riley and IU University hospitals, to transfer a patient from CHNw to above hospital(s) when medically necessary.

C. Is a Bus. Assoc. Agree. Req. under HIPAA Privacy Rules?
YES Included NO ____

D. FORECASTED
YES ____ NO ____
If no, please explain:
N/A

E. PURCHASING Approved?
YES ____ NO ____
If no, please explain:

F. OWNER
By: Ron Lewis
See Attached Date: 5/16/2014

J. CPN COO
By: [signature]
Tony Javorka Date: 6/25/14

K. CPN PRESIDENT
By: [signature]
Dr. Ramarao Yeleti Date: 6/26/14

J. CPE Chief Physician Executive
By: [signature]
Dr. Tim Hobbs Date: 6/25/14

K. DISTRIBUTION OF CONTRACT AFTER FULL EXECUTION:
1. Scanned copy saved to G: drive
2. Original mailed via Interoffice to Legal
4. Enter into Contract Tracking Database
5. Email scanned copy to:

Dept.	Person(s)	Date

*CPN Contract Notification
Copy to Originator

L. Send One Original Contract to address below:

TRANSFER AGREEMENT
BETWEEN
COMMUNITY HEALTH NETWORK
AND
INDIANA UNIVERSITY HEALTH, INC.

THIS AGREEMENT is entered into, by and between Community Health Network, Inc. an Indiana nonprofit corporation and its subsidiaries Community Hospital South, Inc. and Community Howard Regional Health, Inc. (hereinafter "HOSPITAL"), and Indiana University Health, Inc., an Indiana nonprofit corporation (hereinafter "IU Health").

WHEREAS, HOSPITAL is the owner and operator of hospitals commonly referred to as Community Hospital North, Community Hospital East, Community Hospital South, and Community Howard Regional Health;

WHEREAS, the IU Health Academic Health Center in Indianapolis, Indiana includes IU Methodist Hospital, Riley Hospital for Children and IU University Hospital, a Level I adult trauma center at IU Methodist Hospital, a Level I pediatric trauma center at Riley Hospital, specialized research and teaching institutions, physician group practices and clinics, and other organizations related to the delivery and management of health care services; and

WHEREAS, HOSPITAL wishes to maintain a written agreement with IU Health for timely transfer of patients, including trauma patients, between their facilities;

NOW THEREFORE, in consideration of the mutual covenants contained herein, the parties agree as follows:

I. Autonomy. The parties agree that each shall continue to have the exclusive control of the management, business and properties of their respective facilities, and neither party by virtue of this Agreement assumes any liability for any debts or obligations of the other party to the Agreement.

II. Transfer of Patients. Whenever a transfer of a patient from HOSPITAL to IU Health is determined by medical staff at HOSPITAL to be medically necessary and appropriate, HOSPITAL shall notify IU Health of the proposed transfer request and provide such medical and personal patient information as necessary and appropriate to assist IU Health in evaluating and assuming the medical care of the patient upon patient's arrival. IU Health and HOSPITAL shall develop and adhere to any necessary protocols to facilitate such communication and transfer. HOSPITAL shall give notice to IU Health as far in advance as reasonably possible of a proposed transfer. HOSPITAL shall arrange for transportation of the patient. IU Health shall not be responsible for the notification and the safe transfer of the patient to the applicable IU Health facility except to the extent that IU Health is actually involved in providing the transport service.

III. Admission Priorities. Admissions to IU Health shall be in accordance with IU Health's general admission policies and procedures and in accordance with IU

Health's Medical Staff Bylaws and Rules and Regulations. IU Health is not required to give priority of admission to patients to be transferred from HOSPITAL over patients from other transferring facilities. IU Health reserves the right to decline acceptance of a HOSPITAL patient transfer if IU Health is on diversion or otherwise does not have appropriate, available resources to treat the patient.

IV. Medicare Participation. During the term of this Agreement, and any extensions thereof, HOSPITAL and IU Health agree to meet and maintain all necessary Medicare Conditions of Participation and coverage so as to remain approved providers thereunder. HOSPITAL and IU Health shall each be responsible for complying with all applicable federal and state laws.

V. Compliance. HOSPITAL and IU Health agree that any services provided under this Agreement will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to IU Health and/or HOSPITAL, including, but not limited, to regulations promulgated under Title II, Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-91) - "HIPAA" and Title XVIII, Part D of the Social Security Act (42 U.S.C. § 1395dd) – "EMTALA". Furthermore, HOSPITAL and IU Health shall promptly amend the Agreement to conform with any new or revised legislation, rules and regulations to which HOSPITAL and/or IU Health is subject now or in the future including, without limitation, the Standards of Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Laws") in order to ensure that HOSPITAL and IU Health are at all times in conformance with all Laws. If, within ninety (90) days of either party first providing notice to the other of the need to amend the Agreement to comply with Laws, the parties acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate this Agreement immediately.

VI. Interchange of Information and Medical Records. HOSPITAL and IU Health agree to transfer medical and other information and medical records which may be necessary or useful in the care and treatment of patients transferred hereunder as required and permitted by all applicable federal and state laws. Such information shall be provided by HOSPITAL and IU Health in advance, when possible, and where permitted by applicable law. HOSPITAL shall commit to subscribing to a spoke connection to the IU Health Radiology Cloud in order to enhance the timely transmission and reading of diagnostic images at IU Health for transferred patients, particularly trauma patients.

VII. Consent to Medical Treatment. To the extent available, HOSPITAL agrees to provide IU Health with information and assistance, which may be needed by, or helpful to, IU Health in securing consent for medical treatment for the patient.

VIII. Transfer of Personal Effects and Valuables. Procedures for effecting the transfer of personal effects and valuables of patients shall be developed by the parties and subject to the instructions of the attending physician and of the patient and his or her family where appropriate. A standard form shall be adopted and used for documenting the transfer of the patient's personal effects and valuables. HOSPITAL shall be responsible for all personal effects and valuables until such time as possession is accepted by IU Health.

IX. Financial Arrangements. Each party shall each be responsible for billing and collecting for the services which it provides to the patient transferred hereunder from the patient, third party payor or other sources normally billed by each institution. Neither party shall assume any liability by virtue of this Agreement for any debts or other obligations incurred by the other party to this Agreement.

X. Return Transfer of Patients. HOSPITAL will accept transferred patients back from IU Health when medically appropriate and in the best interests of the patient.

XI. Professional and General Liability Coverage. Throughout the term of this Agreement and for any extension(s) thereof, HOSPITAL and IU Health shall each maintain professional and general liability insurance coverage with limits reasonably acceptable to the other party. Each party shall provide the other party with proof of such coverage upon request. HOSPITAL and IU Health shall each maintain qualification as a qualified health care provider under the Indiana Medical Malpractice Act, as amended from time to time, including, but not limited to, proof of financial responsibility and payment of surcharge assessed on all health care providers. Each party shall provide the other party with proof of such qualification upon request.

XII. Indemnification.

12.1. HOSPITAL Indemnification. HOSPITAL agrees that it will indemnify and hold harmless IU Health, its officers, agents, and employees from any loss, cost, damage, expense, attorney's fees, and liability by reason of bodily injury, property damage, or both of whatsoever nature or kind, arising out of or as a result of the sole negligent act or negligent failure to act of HOSPITAL or any of its agents or employees.

12.2. IU Health Indemnification. IU Health agrees that it will indemnify and hold harmless HOSPITAL, its officers, agents, and employees from any loss, cost, damage, expense, attorney's fees, and liability by reason of personal injury or property damage of whatsoever nature or kind, arising out of or as a result of the sole negligent act or failure to act of IU Health or any of its employees or agents.

XIII. Term and Termination.

13.1. Term. The term of this Agreement is for a period of one (1) year from the date hereof, with an automatic renewal of successive one (1) year periods

unless on or before sixty (60) calendar days prior to the expiration of the annual term, one party notifies the other, in writing, that the Agreement is not to be renewed, in which event the Agreement will be terminated at the expiration of the then current annual term.

13.2. Termination.

13.2-1 Either party may terminate this Agreement with or without cause at any time by providing written notice to the other party at least sixty (60) days in advance of the desired termination date.

13.2-2 The Agreement shall terminate immediately and automatically if (i) either IU Health or HOSPITAL has any license revoked, suspended, or nonrenewed; or (ii) either party's agreement with the Secretary of Health and Human Services under the Medicare Act is terminated.

13.2-3 Except as provided for elsewhere in this Agreement, either party may declare this Agreement terminated if the other party does not cure a default or breach of this Agreement within thirty (30) calendar days after receipt by the breaching party of written notice thereof from the other party.

XIV. Notices. Notices or communication herein required or permitted shall be given the respective parties by registered or certified mail, documented courier service delivery or by hand delivery at the following addresses unless either party shall otherwise designate its new address by written notice:

HOSPITAL	IU Health
Community Health Network 7330 Shadeland Station Indianapolis, IN 46256	Indiana University Health, Inc. 340 West 10th Street, Suite 6100 Indianapolis, IN 46206-1367
Attention: President/CEO General Counsel	Attention: President/CEO General Counsel

XV. Assignment. Assignments of this Agreement or the rights or obligations hereunder shall be invalid without the specific written consent of the other party herein.

XVI. Nonexclusive Clause. This is not an exclusive Agreement and either party may contract with other institutions for the transfer of patients while this Agreement is in effect.

XVII. Governing Law. This Agreement shall be construed and governed by the laws of the State of Indiana. The venue for any disputes arising out of this Agreement shall be Marion County, Indiana.

XVIII. Waiver. The failure of either party to insist in any one or more instance upon the strict performance of any of the terms or provisions of this Agreement by the other party shall not be construed as a waiver or relinquishment for the future of any such term or provision, but the same shall continue in full force and effect.

XIX. Severability. If any provision of this Agreement is held by a court of competent jurisdiction to be unenforceable, invalid or illegal, such unenforceability, invalidity or illegality shall not affect any other provision hereof, and this Agreement shall be construed as if such provision had never been contained herein.

XX. Section and Other Headings. The article and other headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

XXI. Amendments. This Agreement may be amended only by an instrument in writing signed by the parties hereto.

XXII. Entire Agreement. This Agreement is the entire Agreement between the parties and may be amended or modified only by a written amendment hereto duly executed by both parties.

XXIII. Execution. This Agreement and any amendments thereto shall be executed in duplicate copies on behalf of HOSPITAL and IU Health by an official of each, specifically authorized by its respective Board to perform such executions. Each duplicate copy shall be deemed an original, but both duplicate originals together constitute one and the same instrument.

IN WITNESS WHEREOF, the duly authorized officers and representatives of HOSPITAL and IU Health have executed this Agreement the 1st day of June, 2014.

HOSPITAL:

COMMUNITY HEALTH NETWORK

By: Timothy Holman

Title: Chief Physician Executive

AND

IU HEALTH:

INDIANA UNIVERSITY HEALTH, INC.

By: _____

Jeffrey Sperring, M.D.
President, IU Health Methodist, Riley and University Hospitals

PATIENT TRANSFER AGREEMENT

This Patient Transfer Agreement ("Agreement") is between the Health and Hospital Corporation of Marion County d/b/a Eskenazi Health and Community Health Network and its subsidiaries Community Hospital South, Inc. and Community Howard Regional Health, Inc. (hereinafter "Hospital"). Eskenazi Health and Hospital are collectively referred to as "Institutions."

Eskenazi Health is a comprehensive public health care system with facilities and services including a hospital, outpatient clinics, inpatient and outpatient mental health services, Level I Trauma Center and the Richard M. Fairbanks Burn Center.

Community Health Network, Inc. and its subsidiaries operate acute care hospitals commonly referred to as Community Hospital East, Community Hospital North, Community Hospital South and Community Howard Regional Health (collective "Hospital")

Eskenazi Health and Hospital have determined that it would be in the best interest of patient care and would promote the optimum use of facilities to enter into a transfer agreement for transfer of patients between the respective Institutions.

Eskenazi Health and Hospital therefore agree as follows:

1. ***Term.*** This Agreement shall become effective beginning June 1, 2014 ("Effective Date") and shall remain in effect for a period of one year from the Effective Date, upon which date the Agreement will automatically renew for additional one-year periods.

2. ***Purpose of Agreement.*** Each Institution agrees to transfer to the other Institution and to receive from the other Institution patients in need of the care provided by their respective Institutions for the purpose of providing improved patient care and continuity of patient care.

3. ***Patient Transfer to Eskenazi Health.*** The request for transfer of a patient from Hospital to Eskenazi Health shall be initiated by the patient's attending physician. Any authorized member of Eskenazi Health's medical staff may authorize a transfer when the patient in question needs Level 1 Trauma Services, interventional radiology, or the services of the Burn Unit if Eskenazi Health has an appropriate bed available and is not on diversion. All other Hospital requests for patient transfers to Eskenazi Health shall be referred to the Bed Control Coordinator/House Supervisor. Prior to moving the patient, Hospital must receive confirmation from Eskenazi Health that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Sidney & Lois Eskenazi Hospital.

4. ***Patient Transfer to Hospital.*** The request for transfer of a patient from Eskenazi Health to Hospital shall be initiated by the patient's attending physician. Any

authorized member of Hospital's medical staff may authorize a transfer if Hospital has an appropriate bed available and is not on diversion. Prior to moving the patient, Eskenazi Health must receive confirmation from Hospital that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Hospital's Emergency Department.

5. ***Patient Records and Personal Effects.*** Each of the Institutions agrees to adopt standard forms of medical and administrative information to accompany the patient from one Institution to the other. The information shall include, when appropriate, the following:

A. Patient's name, address, hospital number, and age; name, address, and telephone number of the patient's legal guardian (if applicable);

B. Patient's third-party billing data;

C. History of the injury or illness;

D. Condition on admission;

E. Vital signs prehospital, during stay in emergency department, and at time of transfer;

F. Treatment provided to patient; including medications given and route of administration;

G. Laboratory and X-ray findings, including films;

H. Fluids given, by type and volume;

I. Name, address, and phone number of physician referring patient;

J. Name of physician in receiving Institution to whom patient is to be transferred; and

K. Name of physician at receiving Institution who has been contacted about patient.

L. Specialized needs and dietary restrictions.

Each Institution shall supplement the above information as necessary for the maintenance of the patient during transport and treatment upon arrival at the receiving Institution, and the Institutions shall work together to reduce repetition of diagnostic tests. Transfers of Protected Health Information (PHI) shall comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

In addition, each Institution agrees to adopt a standard form to inventory a patient's personal effects and valuables that shall accompany the patient during transfer. The records described above shall be placed in the custody of the person in charge of the transporting medium who shall sign a receipt for the medical records and the patient's valuables and personal effects and in turn shall obtain a receipt from the receiving Institution when it receives the records and the patient's valuables and personal effects. The transferring Institution shall bear responsibility for the loss of the patient's personal effects and valuables unless it can produce an authorized receipt for the personal effects and valuables from the accepting Institution.

6. ***EMTALA Compliance and Transfer Consent.*** The transferring Institution shall have responsibility for meeting the requirements for an "appropriate transfer" under the Emergency Medical Treatment and Active Labor Act (EMTALA), if applicable. The transferring Institution is responsible for obtaining the patient's consent to the transfer to the other Institution prior to the transfer, if the patient is competent. If the patient is not competent, the transferring Institution shall obtain a family member's consent; if such consent is not possible, the consent of the patient's physician shall be obtained by the transferring Institution.

7. ***Payment for Services.*** The patient is primarily responsible for payment for care received at either Institution. Each Institution shall be responsible only for collecting its own payment for services rendered to the patient. No clause of this Agreement shall be interpreted to authorize either Institution to look to the other Institution to pay for services rendered to a patient transferred by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

8. ***Transportation of Patient.*** The transferring Institution shall have responsibility for arranging transportation of the patient to the other Institution, including selection of the mode of transportation and providing appropriate health care practitioner(s) to accompany the patient if necessary. The receiving Institution's responsibility for the patient's care shall begin when the patient is admitted, either as an inpatient or an outpatient, to that Institution.

9. ***Advertising and Public Relations.*** Neither Institution shall use the name of the other Institution in any promotional or advertising material unless review and approval of the intended advertisement first shall be obtained from the party whose name is to be used. Both Institutions shall deal with each other publicly and privately in an atmosphere of mutual respect and support, and each Institution shall maintain good public and patient relations and efficiently handle complaints and inquires with respect to transferred or transferring patients.

10. ***Independent Contractor Status.*** Both Institutions are independent contractors. Neither Institution is authorized or permitted to act as an agent or employee of the other. Nothing in this Agreement shall in any way alter the freedom enjoyed by

either Institution, nor shall it in any way alter the control of the management, assets, and affairs of the respective Institutions. Neither party, by virtue of this Agreement, assumes any liability for any debts or obligations of either a financial or a legal nature incurred by the other party to this Agreement.

11. ***Liability.*** Hospital shall save, indemnify, and hold Eskenazi Health harmless of and from any and all liability, loss, costs, and expenses incurred directly or indirectly from any acts, errors, or omissions by Hospital, its agents, employees or invitees from any cause arising out of or relating to Hospital's performance under this Agreement. Any obligation of Hospital to save and hold Eskenazi Health harmless is limited in substance by statutes designed to protect and limit the exposure and liability of Hospital as a qualified health care provider under the Indiana Medical Malpractice Act.

Eskenazi Health shall save, indemnify, and hold Hospital harmless of and from any and all liability, loss, costs, and expenses incurred directly or indirectly from any acts, errors, or omissions by Eskenazi Health, its agents, employees or invitees from any cause arising out of or relating to Eskenazi Health's performance under this Agreement.

Any obligation of Eskenazi Health to save and hold Hospital harmless is limited in substance by statutes designed to protect and limit the exposure and liability of Eskenazi Health as an instrumentality of the State of Indiana under the Indiana Tort Claims Act and as a qualified health care provider under the Indiana Medical Malpractice Act.

12. ***Exclusion.*** Institutions represent and warrant that the Institution, its employees, directors, officers, subcontractors, and agents are not under sanction and/or have not been excluded from participation in any federal or state program, including Medicare or Medicaid.

13. ***Insurance.*** Each Institution shall maintain at all times throughout the term of this Agreement commercially reasonable insurance, including but not limited to, comprehensive general liability insurance, professional liability insurance, and property damage insurance. Upon request, each Institution shall provide the other with written documentation evidencing such insurance coverage.

14. ***Termination.***

A. *Voluntary Termination.* This Agreement shall be terminated by either party for any reason, by giving thirty (30) days' written notice of its intention to withdraw from this Agreement, and by ensuring the continuity of care to patients who already are involved in the transfer process. To this end, the terminating party will be required to meet its commitments under the Agreement to all patients for whom the other party has begun the transfer process in good faith.

B. *Involuntary Termination.* This Agreement shall be terminated immediately upon the occurrence of any of the following:

1. Either Institution is destroyed to such an extent that the patient care provided by such Institution cannot be carried out adequately;

2. Either Institution loses its license or accreditation;

3. Either Institution no longer is able to provide the service for which this Agreement was sought; and

4. Either Institution is in default under any of the terms of this Agreement.

5. Either Institution have been debarred, excluded or otherwise determined ineligible from participation in any federal or state program, including Medicare and Medicaid.

14. ***Nonwaiver.*** No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term or condition of this Agreement.

15. ***Governing Law.*** This Agreement is governed by the laws of the State of Indiana. Any litigation arising out of this Agreement shall be brought in a court located in Marion County, Indiana.

16. ***Assignment.*** This Agreement shall not be assigned in whole or in part by either party without the express written consent of the other party.

17. ***Invalid Provision.*** In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

18. ***Amendment.*** This Agreement may be amended at any time by a written agreement signed by the parties.

19. ***Notice.*** Any notice required or allowed to be given under this Agreement shall be deemed to have been given upon deposit in the United States mail, registered or certified, with return receipt requested. Any and all notices are to be addressed as follows:

ESKENAZI HEALTH:
Eskenazi Health
Attn: Legal Department
720 Eskenazi Avenue
FOB 5th Floor

Indianapolis, IN 46202

COMMUNITY HEALTH NETWORK:
Community Hospital Network
Attn: Legal Department
7330 Shadeland Station
Indianapolis, IN 46256

20. ***Entire Agreement.*** This Agreement constitutes the entire agreement between the parties and contains all of the agreements between them with respect to its subject matter and supersedes any and all other agreements, either oral or in writing, between the parties to the Agreement with respect to the subject matter of this Agreement.

21. ***Binding Agreement.*** This Agreement shall be binding upon the successors or assigns of the parties.

22. ***Authorization for Agreement.*** The execution and performance of this Agreement by each Institution has been duly authorized by all necessary laws, resolutions, or corporate actions, and this Agreement constitutes the valid and enforceable obligations of each Institution in accordance with its terms.

Eskenazi Health and Hospital are each signing this Agreement on the date stated below that party's signature.

THE HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY D/B/A ESKENAZI HEALTH

Lisa Harris MD

Lisa Harris, CEO and Medical Director

Date: 6/24/14

COMMUNITY HEALTH NETWORK

By: [signature]

Title: Chief Physician Exec.

Date: 6/27/14

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 11

Trauma OR, Staff and Equipment

11. "**Trauma Operating Room, staff, and equipment.** There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services 24 hours per day. The application must also include a list of essential equipment available to the OR and its staff."

Narrative Response and Discussion

The requirements of section 11 are met with a letter of commitment from Community Hospital South's Chief of Anesthesiology affirming 24 hour availability of anesthesiologist services. Also included is the OR staff and equipment list for the Operating Rooms.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 16, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of the correspondence is to inform the committee that I serve as Anesthesiologist Chairman. I am pleased to support Community Hospital South's effort to complete "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that a qualified anesthesiologist is promptly available twenty – four hours per day. I attest that we have adequate anesthesia equipment to provide trauma services including neurosurgical procedures.

An anesthesiologist liaison will attend at least 50% of the PIPS committee meetings and actively participate in performance improvement process.

Respectfully,

Andrew Corsaro, M.D.
Department Chairman
Department of Anesthesia

Edward Diekhoff M.D., F.A.C.S
Trauma Medical Director

122

Community Health Network

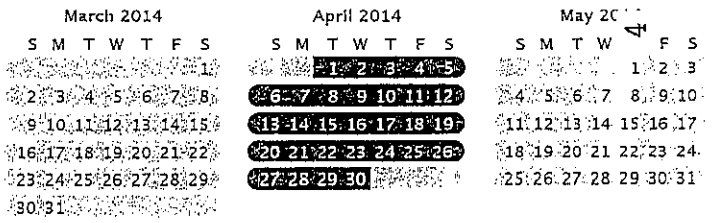
Community Hospital South
1402 E. County Line Road
Indianapolis, IN 46227
eCommunity.com

Community Hospital South
Operating Room Equipment

The equipment listed below is available 24 hours per day.

- Glide-scope for video intubation
- Difficult Airway Cart with brochoscopy
- Monitors for basic vital signs and invasive monitoring
- BIS Monitors
- Bair Hugger-patient warming
- Cautery-Monopolar
- Cautery-Bi-polar
- Suction
- Tourniquets
- Headlights
- Hotline Fluid Warmer
- IV Pumps
- C-arm
- Fluoroscopy
- Power Injector
- Portable x-ray
- X-ray aprons
- PACS system
- Crash Cart with bronchoscopy
- Cell saver
- Sponge counter system
- Bladder Scanner
- **OR Tables**
  - ✓ Hana Table (Hip Fractures)
  - ✓ Axis Jackson Table
  - ✓ Jackson Table with flat top frame
  - ✓ Wilson Frame (regular OR table)
  - ✓ Wilson Frame-Spine & Craniotomy Procedures
  - ✓ OSI Hydraulic Floating Table
  - ✓ Hand Table
- **Orthopedics**
  - ✓ Drills
  - ✓ Basic Instruments
  - ✓ Specialized Instruments
  - ✓ Implant Sets
  - ✓ Major and Minor Instrumentation
- **Neurosurgical**
  - ✓ Basic and Specialized Instrumentation
  - ✓ Implants
  - ✓ Midas Rex Drills
  - ✓ Navigation system and O-arm
  - ✓ Aneurysms Clips
  - ✓ Camino Monitor
  - ✓ Ventriculosotomy Set
  - ✓ Mayfield Head Holder

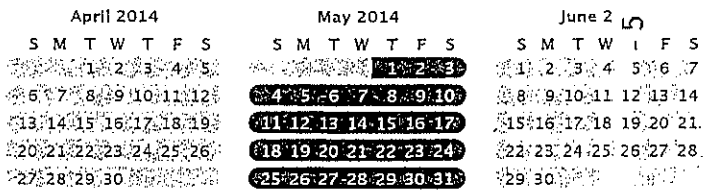
April 2014



CALL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
31		1 PATRON 7:00 AM Ngo B/U OpsMtg-7am	2 NGO 7:00 AM ~~Stuart B/U~~ Mapalad B/U	3 ~~Sukay~~ 7:00 AM ~~Labarge B/U~~ ~~Corsaro B/U~~ Labarge B/U Patron (out by 4:30 Plus)	4 LABARGE 7:00 AM ~~Popovic B/U~~ ~~Sukay~~ ~~Corsaro B/U~~ Mapalad B/U	5 LABARGE 7:00 AM ~~Popovic B/U~~ ~~Sukay~~ ~~Corsaro~~ Mapalad B/U
6 LABARGE 7:00 AM ~~Popovic B/U~~ ~~Sukay~~ ~~Corsaro~~ Mapalad B/U	7 ~~POPOVIC~~ ~~Corsaro~~ ~~Sukay~~ Mapalad 7:00 AM ~~Parker B/U~~ Burton B/U	8 PARKER 7:00 AM McGee B/U Corsaro/Patel-4-1epm mtg@ Comm. North ~~Corsaro~~ McGee 7-8am meeting	9 MCGEE 7:00 AM Patron B/U	10 PATRON 7:00 AM ~~Stuart~~ B/U Sukay	11 STRAIN 7:00 AM ~~Sukay B/U~~ LaBarge B/U	12 STRAIN 7:00 AM ~~Sukay B/U~~ LaBarge B/U
13 STRAIN 7:00 AM ~~Sukay B/U~~ LaBarge B/U Corsaro	14 ~~PATRON~~ LABARGE 7:00 AM Mapalad B/U PATRON	15 MAPALAD 7:00 AM Stuart B/U	16 ~~STUART~~ Sukay 7:00 AM Ngo B/U	17 NGO 7:00 AM ~~Burton B/U~~ Corsaro B/U	18 Corsaro ~~BURTON~~ LABARGE 7:00 AM ~~Labarge B/U~~ ~~Sukay B/U~~ Patron B/U Labarge	19 Corsaro ~~BURTON~~ LABARGE 7:00 AM ~~Labarge B/U~~ ~~Sukay B/U~~ Patron B/U
20 ~~BURTON~~ LABARGE 7:00 AM ~~Labarge B/U~~ ~~Sukay B/U~~ Patron B/U Labarge	21 LABARGE ~~Sukay~~ 7:00 AM Popovic B/U	22 POPOVIC 7:00 AM Parker B/U	23 ~~Labarge~~ Sukay 7:00 AM McGee B/U meeting until 9a corsaro, Patel, & Strain	24 MCGEE 7:00 AM Corsaro B/U ~~Corsaro~~ ~~Popovic~~ BURTON B/U CORSARO-mtg 7a-8a	25 Labarge CORSARO ~~Popovic~~ ~~Labarge~~ 7:00 AM ~~Strain~~ B/U ~~Sukay~~ Sukay	26 Labarge CORSARO ~~Popovic~~ ~~Labarge~~ 7:00 AM ~~Strain~~ B/U ~~Strain~~ Sukay
27 CORSARO ~~Popovic~~ ~~Labarge~~ 7:00 AM ~~Strain~~ B/U ~~Strain~~ Sukay	28 ~~Sukay~~ 7:00 AM ~~Sukay~~ B/U ~~Popovic~~ Patron B/U	29 ~~Sukay~~ ~~Corsaro~~ Patron 7:00 AM Mapalad B/U	30 MAPALAD 7:00 AM ~~Patron~~ B/U Popovic B/U			

May 2014

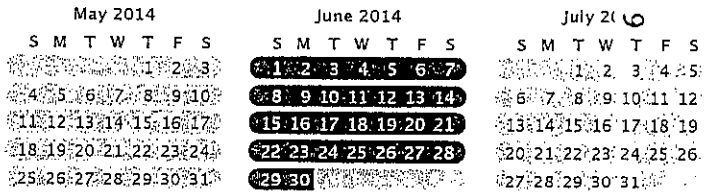


CALL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
27	28	29	30	1 PATRON Popovic 7:00 AM ~~Ngo B/U~~ Sukay B/U Board Mtg - 7am	2 NGO Sukay 7:00 AM Stuart B/U	3 NGO Sukay 7:00 AM Stuart B/U
4 NGO Sukay 7:00 AM Stuart B/U	5 STUART LaBarge 7:00 AM Labarge B/U	6 LABARGE 7:00 AM Popovic B/U ~~Patel/Corsaro 7-8 meeting~~	7 POPOVIC 7:00 AM Parker B/U	8 PARKER 7:00 AM ~~McGee~~ B/U LaBarge B/U Patron Surgery @ end of day	9 MCGEE LABARGE 7:00 AM Corsaro B/U	10 MCGEE LABARGE 7:00 AM Corsaro B/U
11 MCGEE LABARGE 7:00 AM Corsaro B/U	12 CORSARO 7:00 AM Strain B/U Board Mtg 7AM	13 STRAIN 7:00 AM Sukay B/U Patel/Corsaro-7-8 meeting 7-8am meeting McGee VEI Board Mtg	14 SUKAY NGO 7:00 AM Mapalad B/U McGee out by 3:30	15 MAPALAD 7:00 AM ~~Patron~~ B/U Popovic B/U	16 PATRON Popovic 7:00 AM McGee B/U Strain - 7:30-8:30 Mtg	17 PATRON Popovic 7:00 AM ~~McGee B/U~~ Corsaro B/U
18 PATRON Popovic 7:00 AM McGee B/U	19 MCGEE 7:00 AM ~~Burton B/U~~ Labarge ~~Strain B/U~~ Patel Dinner 5:30	20 PATRON Capital Grille 7:00 AM ~~Labarge B/U~~ STRAIN 1-4 Patel	21 LABARGE 7:00 AM Popovic B/U	22 POPOVIC 7:00 AM Ngo B/U Patron out by noon/12:30 if poble.	23 NGO 7:00 ~~AM Mapalad B/U~~ Corsaro Sukay B/U P.	24 SUKAY MAPALAD 7:00 AM ~~Ngo B/U~~ Burton B/U
25 MAPALAD 7:00 AM ~~Ngo B/U~~ Burton B/U	26 MAPALAD 7:00 AM Ngo B/U	27 CORSARO 7:00 AM ~~Strain B/U~~ PATRON B/U	28 STRAIN Patel 7:00 ~~AM Sukay B/U~~ Strain	29 SUKAY 7:00 AM Parker B/U Patron out by noon please CORSARO - mtg 4p-5p	30 PARKER LABARGE 7:00 AM ~~Patron B/U~~ Sukay B/U Cosaro B/U	31 PARKER LABARGE 7:00 AM ~~Patron B/U~~ Sukay B/U

Eastern Time Time

June 2014



CALL

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 PARKER 7:00 AM ~~Patron B/U~> Sakay B/U	2 PATRON Sakay 7:00 AM Ngo B/U	3 McGee 7:00 AM Stuart B/U Corsaro - 3-4 meeting	4 STUART 7:00 AM Labarge B/U	5 LABARGE 7:00 AM ~~Popovic~~ B/U PATRON B/U Corsaro - 3-4pm meeting	6 POPOVIC Patron 7:00 AM ~~Mapalad B/U~> Popovic B/U Strain - 7am meeting	7 POPOVIC Patron 7:00 AM ~~Mapalad B/U~> Popovic B/U
8 POPOVIC Patron 7:00 AM ~~Mapalad B/U~> Popovic B/U	9 Popovic 7:00 AM McGee B/U Corsaro	10 Ngo 7:00 ~~AM Corsaro B/U~> Sakay B/U 7-8 am meeting M'ker	11 ~~LABARGE~~ Corsaro 7:00 AM Strain B/U Sakay	12 STRAIN 7:00 AM ~~Sakay B/U~> Mapaland	13 SAKAY 7:00 AM ~~Parker~~ B/U - Strain ~~Burton BU~> McGee 8/8:30 start Epos	14 ~~PARKER~~ ~~SAKAY~~ MAPALAD 7:00 AM ~~Burton~~ B/U Burton BU C-1 - 3pm - noon Surg Dr. Ross talk
15 SAKAY 7:00 AM ~~Parker~~ B/U Burton BU until noon - C-1-	16 ~~PATRON~~ 7:00 AM ~~Patron B/U~~ McGee B/U	17 PATRON 7:00 AM Ngo B/U	18 NGO 7:00 AM Burton B/U Patron out by 1:30	19 BURTON Sakay 7:00 AM ~~Labarge B/U~> McGee B/U Corsaro - 3-4:30 meeting PATRON - out by 3:15 (4pm closing)	20 LABARGE MCGEE 7:00 AM Popovic B/U	21 LABARGE MCGEE 7:00 AM Popovic B/U 17
22 ~~LABARGE~~ MCGEE 7:00 AM Popovic B/U	23 POPOVIC 7:00 AM Parker B/U	24 PARKER 7:00 AM McGee B/U	25 MCGEE 7:00 AM Corsaro B/U	26 ~~STUART~~ Parker 7:00 AM Strain B/U 7am-8am - corsaro - meeting	27 STRAIN 7:00 AM ~~Sakay B/U~> Popovic Corsaro - 4pm meeting	28 STRAIN 7:00 AM ~~Sakay B/U~> Popovic
29 STRAIN 7:00 AM ~~Sakay B/U~> Popovic	30 ~~LABARGE~~ Popovic 7:00 AM Mapalad B/U					

Eastern Time Time z

CHS Surgical Services Call List

Date: _____

CALL COORDINATOR: person is to be called first and is responsible for calling in all on-call personnel.
OPERATOR: at a physician's request, please release the Call Coordinator's contact information.

Coordinator

Name	Time	1st Contact #	Alternate #	Pager

Surgery Staff

Call 1 Name	Time	1st Contact #	Alternate #	Pager

Call 2

Recovery Staff

Call 1 Name	Time	1st Contact #	Alternate #	Pager

Call 2

Late Stay

Endoscopy Staff

Call 1 Name	Time	1st Contact #	Alternate #	Pager

Call 2

Anesthesia	1st Contact #	Alternate #	Pager
P. Burton, MD			
A. Corsaro, MD			
S. LaBarge, MD			
J. Mapalad, MD			
R. McGee, MD			
D. Ngo, MD			
A. Parker, MD			
B. Patel, MD			
R. Patron, MD			
R. Popovic, MD			
C. Strain, MD			
J. Stuart, MD			
C. Sukay, MD			

Anesthesia Call_____ Anesthesia Back-up_____

Surgical Services Leadership

Patrick Beaupre			
Jill Thomas			
Mark Walke			

CETECH, Cell Saver:

	530020-OR									
1	Best	W	Christopher	1	5/9/11		CST	8/1/15	n/a	n/a
2	Browning	L	Kylie	0.6	8/15/05		2/7/14 CST	2/1/15	n/a	n/a
3	Caudill	A	Julie	1	6/10/13		RN	3/1/16	9/1/15	5/1/16
4	Collier	M	James	1	6/28/10		RN	3/1/15	3/1/15	5/1/15
5	Dobbs	S	Erika	1	5/13/13		RN	5/1/16	7/1/15	5/1/16
6	Edwards	E	Christopher	prn	5/6/13		RN	7/1/15	10/1/15	
7	Frost	H	Ted	prn	7/24/94		RN	2/1/15	11/1/15	
8	Fultz	L	Jetta	0.75	5/17/04		9/1/11-CST	10/1/15	n/a	n/a
9	Hines	M	Lauree	1	8/12/96		CST	4/1/15	n/a	n/a
10	Hoeping	A	Melissa	1	2/4/13		RN	9/1/15	9/1/14	8/1/15
11	Huddleston	L	Julie	1	12/5/11		RN	2/1/15	3/1/15	
12	Huffman	W	Marcia	prn	9/1/92		RN	3/1/15	4/30/15	
13	Hurst	J	Melanie	0.9	3/14/11		RN	4/1/15	4/30/15	5/1/16
14	Hutson	L	Tessa	prn	5/5/14		RN	5/1/15	9/1/15	
15	Kipfer	L	Carma	1	7/14/04		RN	11/1/15	3/1/16	
16	Madden	A	Scott	1	05/1988		n/a	3/1/15	n/a	n/a
17	Manowitz	A	Cynthia	prn	12/7/06		CST	4/1/16	n/a	n/a
18	Mobley	S	Kimberly	1	8/30/10		CST	8/1/15	n/a	n/a
19	Munoz	A	Kelly	1	5/26/98		RN	3/1/15	4/1/16	
20	Payne	D	Cherise	1	7/1/13		12/8/16-CST	4/1/15	n/a	n/a
21	Perry	B	Chelsy	0.9	11/12/10		RN	11/1/15	1/1/16	5/1/16
22	Robertson *	L	Diana	1	4/2005		RN	11/1/15	2/1/16	1/1/16
23	Storm	A	Danielle	1	12/5/11		RN	7/1/15	3/1/15	
24	Yeager	A	Julie	0.6	07/1993		RN	11/1/15	7/1/15	
	530070-PACU/POCU									
25	Burris		Kenneth	1	1/5/09		RN	11/1/15	2/1/16	8/1/15
26	Cala	J	Susan	0.8	6/1/92		RN	7/1/15	1/1/16	1/1/16
27	Case	R	Nikki	0.8	05/2002		RN	3/1/15	1/1/15	5/1/16
28	Cox	J	Pamela	0.9	8/23/82		RN	2/1/15	1/1/15	1/1/16
29	Franklin	D	Michelle	1	6/18/12		RN	9/1/15	9/1/15	9/1/15
30	Hamilton		Michelle	1	3/7/11		RN	10/1/15	2/1/16	10/1/15
31	Hendley		Bess Anne	1	5/8/90		RN	11/1/15	9/1/15	10/1/15
32	Holland	R	Cynthia	1	12/17/12		RN	11/1/15	8/1/15	4/1/15
33	Kocher	L	Maureen	0.6	05/1983		RN	11/1/15	3/1/15	2/1/16
34	Lobdell-Monroe	L	Donna	0.9	08/1990		RN	2/1/15	7/1/15	2/1/16
35	McCorkle	J	Barbara	0.75	10/2005		RN	2/1/15	7/1/15	2/1/15
36	Monnett-Kelsey	R	Jill	prn	4/15/13		RN	5/1/16	8/1/15	8/1/15
37	Patel	G	Alisha	prn	4/3/14		RN	5/1/16	5/1/16	5/1/16
38	Patterson	L	Ashley	1	3/7/11		RN	4/1/15	5/1/16	10/1/15
39	Peters	R	Dena	prn	10/31/11		RN	2/1/15	2/1/15	8/1/15
40	Strain	N	Brandi	prn	12/1995		RN	2/1/15	4/1/15	2/1/16
41	Wilson	J	Aggie	prn	5/17/04		RN	2/1/15	2/1/15	10/1/15
42	Woods		Ashlie	prn	6/11/12		RN	7/1/14	7/1/14	7/1/14
43	Young	M	Lynne	1	6/26/06		RN	11/1/15	7/1/15	5/1/15
	530080-Endo									
44	Black	L	Ellen	0.8	1/1/89		10/1/06 CST	10/1/15	n/a	n/a
45	Fase	J	April	1	9/30/13		RN	7/1/14	8/1/15	n/a
46	Ogden	E	Katrina	1	8/19/13		RN	11/1/15	10/1/15	n/a
47	Poff	M	Evelyn	1	5/13/14		RN	5/1/16		n/a
48	Puckett	M	Tammy	1	5/2002		RN	11/1/15	4/1/16	2/1/15

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 9/16/10

NPP#: ORSPP: S-05
Page 1 of 1
EFFECTIVE: 6/12/14

TITLE: STAFFING

Performed by: Team Leader or Designee

Purpose: To provide guidelines for staffing in Surgical Services

General Information: None

Policy Statements:

1. A Registered Nurse will be assigned to perform circulating duties in each Operating Room.
2. A Registered Nurse, Surgical Technologist, Certified Surgical Tech, Student Surgical Technologist (SST), CSTFA or a trained Student Extern will be assigned to scrubbing duties as appropriate.
3. The demands of each room schedule will be optimally matched with skills and expertise of assigned staff.
4. Assignment of additional personnel per procedure will be provided, with consideration to:
    a. Acuity/complexity of procedure (eg trauma, total joint replacement).
    b. Physician request (eg scrub assistant).
    c. Special equipment (eg laser).
5. One CHI competency verified laser nurse will be assigned to each laser procedure.
6. Department Coverage
    a. CHE: Department coverage consists of in house RN staffing 0700-2300 Monday-Friday and 0700-1900 on Saturday and Sunday - - with the exception of holiday coverage. CHE Monday – Sunday, 1900 – 0700, weekends and holidays will be covered by a designated on-call team consisting of at least one RN.
    b. CHN: Department coverage consists of in house RN staffing 24 hours a day. Holiday call is covered by a designated on-call team consisting of at least one RN.
    c. CHS: Department coverage consists of in house RN staffing 0700-1830 Monday-Friday. Weekday nights (1830-0700), weekends, and holidays are covered by a designated on-call team consisting of at least one RN.
    d. CHVH: Department coverage consists of in house RN staffing 0630-1700 Monday-Friday. Outside of timeframe is an on-call team.

Equipment: None

Procedure: None

Documentation Guidelines: None

References: None

Approved by:	Perioperative NPP Subcommittee	Date: 5/2014
	Infection Prevention	Date: 5/14/2014
	Risk Management	Date: 5/14/2014
	CHVH	Date: 5/14/2014
Approved:	NPP Steering Committee	Date: 5/14/2014

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE NPP: ORSPP: S-02
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/25/08 EFFECTIVE: 6/13/14

TITLE: SCHEDULING GUIDELINES FOR SURGICAL PROCEDURES

Performed by: RN, LPN, Patient Data Coordinator

Purpose: To provide guidelines for scheduling elective and emergency surgical procedures.

Policy Statements:

1. The administration of Surgical Services is a cooperative effort between the Surgical Services Leadership and the respective Medical Directors.
2. The Director or designee (Clinical Director, Team Leader) is responsible for the provision of nursing and ancillary personnel, as well as appropriate functioning physical facilities.
3. The Medical Director of Surgical Services is responsible for matters involving the physicians utilizing Surgical Services.
4. Inpatient surgical procedures on patients under 14 years of age necessitating admission to the ICU will be done only under emergency circumstances. These surgeries will require a collaborative effort of Surgical Services Leadership, Pediatrics, and ICU (or their designee) and any associated Medical Director(s).
5. All surgical cases scheduled will be done in accordance with infection prevention policies and AORN Recommended Practices.

Definitions

6. **Add On/Urgent Procedure**: Surgery cases added to the current or next day's surgery schedule after the official schedule has been closed or published. These procedures are not immediately life-threatening but are expedited and worked into the schedule as soon as possible.
7. **Block Scheduling**: A system of reserving specific routine periods of operating room time for individual and/or group practice based upon a defined pattern of utilization.
8. **Elective Procedures**: Surgical cases scheduled in advance into assigned block or open time available for surgeons without assigned block time
9. **Emergent Procedure**: A life/limb threatening condition that requires immediate surgical intervention. An emergency goes into the first available room and may require bumping the start of another surgery or rearranging the prescheduled cases. If bumping another case is necessary, it is the surgeon's responsibility to notify the surgeon whose scheduled case is affected.
10. **First Case On Time Start**: Applies to first case in every room with a start time before 9 AM.
11. **Open Time Scheduling**: Periods of operating room time unreserved and available for scheduling on a first come first serve basis. Surgeons without block time have priority for scheduling in unreserved time.
12. **Release Time**: Automatic release time for unused block time converting to open time. Occurs automatically 5 days prior to actual date if no elective cases are scheduled.
13. **Scheduled Start Time**: The scheduled start time is defined as "the patient in the room time."
14. **Turnover Time**: The time the patient leaves the room until the time the next patient enters the room. This includes the clean-up and set up time during this time frame.

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE NPP: ORSPP: S-02
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/25/08 EFFECTIVE: 6/13/14

General Information:

1. The OR Services consists of:
   A. CHE
      1. Five (5) operating rooms, two (2) endoscopy rooms and one (1) pain management room.
      2. All types of surgical procedures may be performed with the exception of organ transplants, and procedures requiring cardiopulmonary bypass.
      3. These specialties should be scheduled in designated rooms to facilitate access to supplies and equipment:

Neurosurgery	OR# 12, 14
Urology	OR# 4
Peripheral vascular	OR #4, 7, 12, 14
Orthopedics	OR# 10, 12
Total Joints	OR# 10, 12
Thoracic	OR# 12, 14
Endoscopy	OR # 8, 9
Pain Management	OR #1

General and gynecology surgeries may be scheduled in any available room.

   B. CHN
      1. Eight (8) general, multipurpose rooms.
      2. All types of surgical procedures may be performed with the exceptions of organ transplants and procedures requiring cardiopulmonary bypass.
      3. NICU surgical patients are a collaborative effort among the Neonatal Nurse Practitioner, the Medical Director of the NICU, Surgical Services Leadership, and the Medical Director of Anesthesiology.

   C. CHS
      1. Six (6) general, multipurpose surgical suites.
      2. Surgical procedures may be performed with the exception of organ transplants and procedures requiring cardiopulmonary bypass.

   D. CHVH
      1. Four (4) general, multipurpose operating rooms. Three (3) rooms are available for scheduling and are staffed Monday through Friday from 0715-1700.
      2. There is one (1) hybrid operating room. When the hybrid OR is utilized and staffed with OR personnel, then there will only be two (2) general rooms available.

2. Availability of time on the OR schedule is determined by:
   A. Type of anesthesia required.
   B. Nursing personnel availability.
   C. Supply and equipment availability (eg, laser, x-ray).
   D. Length of time needed for procedure, including set-up time, operating time and clean up time.

3. Information to be requested when scheduling includes, but is not limited to:
   A. Date and time requested, surgeon's name, type of anesthesia, procedure to be performed, patient's name, phone number, and date of birth, patient's status (inpatient, outpatient, a.m. admit, 23 Hour Observation), length of time needed, equipment needed.

4. Cancellation
   A. The surgeon informs the CHE office CHN or scheduling office ıd CHVH
   B. Should a patient fail to report at the pre-determined time, the surgeon is notified.
   C. Cancellations may be made by the surgeon and/or anesthesia after the patient has arrived if a patient fails to have completed pre-surgery requirements (lab work, consent, registration, etc.)
   D. The OR Team Leader or Clinical Manager or designee in conjunction with the Medical Director of Surgical Services may adjust the day's schedule to facilitate the day.
   E. If there is a cancellation or change in schedule:
      i. Scheduled cases will be offered earlier times first at the discretion of the Medical Director and/or charge nurse or designee,
      ii. Add-on cases will be considered next

Procedure:

1. Elective Surgery
   A. CHE
      1. The scheduling office is open between the hours of 0800-1700 M-F. Scheduling may be accomplished via telephone (355-5489). Requests may be called to the OR Department when the office is closed.
         a. Monday-Friday 6:30am to 7 pm. Saturday and Sunday 7am-7pm with call coverage all other times and holiday. The OR is staffed 24 hours a day, 7 days a week, except holidays.
      2. Procedures scheduled via phone, or in person should include the information in "General Information 4".
      3. Requests are accepted only from the physician or personnel employed by the physician.
      4. The operating rooms are routinely be utilized for elective scheduling Monday-Friday, between the hours of 0700-1800.
         a. One (1) room may begin at 0700 am or 0730 am if deemed necessary by the Team Leader and/or Medical Director.
         b. Three (3) rooms will be staffed until 1~~7~~530, two (2) rooms will be staffed until 1730 pending staffing needs.
      5. The elective schedule for the next day closes at 1700 on the day prior. All procedures for the next day that are scheduled after this time, are considered add-ons and should be scheduled through the OR Team Leader or designee.
      6. An open scheduling system is used. Room assignments are on a first come, first served basis. Every effort is made to ensure that the same surgeon follows himself/herself.

7. Only emergent procedures are performed on Thanksgiving, Christmas, New Year's Day, Memorial Day, July 4th and Labor Day. Friday after Thanksgiving, one room covered by on-call. Medical Director opens a second room if deemed necessary.

B. CHN
1. The scheduling office is open between the hours of 0700 to 1630, Monday-Friday. Scheduling may be accomplished by telephone or in person.
   a. Inpatients, a.m. admissions, and observations are to have a bed reservation.
   b. Only emergencies and urgent cases are done after the scheduled OR hours.
   c. The OR is staffed 24 hours a day, 7 days a week, except holidays. Holidays are covered by a designated On-Call Team.
2. Procedures scheduled via phone or in person should include the information in "General Information CHN 4".
3. Requests are accepted only from the physician or personnel employed by the physician.
4. The elective schedule for the next day closes at 1630 on the day prior. All procedures for the next day that are scheduled after this time are considered add-ons.
   a. On weekends and holidays, requests for scheduling on the next business day are accepted by calling surgery at
   b. If the department has staff on duty, the surgeon may call and give all information to the staff person on duty who passes the request on to the Clinical Manager/Team Leader/Designee on the next business day. A return call the following business morning confirms the receipt and disposition of these requests.
5. Block scheduling guidelines.
   a. There is a combination of block and open scheduling.
   b. There is a combination of block and open scheduling time.
   c. Block time owners may not allocate their block time to another surgeon.
   d. CHN/CHE/CHS-Block is released 168 hours (7 days) prior to scheduled block time if the time is not utilized.
   e. CHVH-Block time is released 120 hours (5 business days) prior to scheduled block time if the time is not utilized.
   f. Quarterly evaluation of block time is performed by Surgical Services leadership and the Medical Director. Adjustments can be made after consultation with the surgeon according to the percentage of block time utilized.
   g. CHVH-To maintain block time, utilization must be at least 75% as measured on a quarterly basis. A calculation of turnover time is included towards block time utilization.
      i. Block time owners are made aware of utilization on a quarterly basis. If at the end of a quarter, utilization is below 75%, the owner has the next quarter to improve utilization to 75%. If 75% is not met, adjustments to decrease the block time are made.
      ii. Prior to adjustments of decreasing time, outside factors are taken into consideration (ie. surgeon in front of you consistently runs over into your block time thereby preventing you from reaching 75% utilization).

iii. Utilization above 75% is evaluated on a quarterly basis to determine if an increase in time is needed.
iv. Time utilized outside of assigned block time is not be allocated toward block time utilization.
v. Block Utilization % = hours used inside the block + allowed turnover time (less approved released time)
block hours allocated (less approved released time)

h. If a surgeon has block time that covers the first case of the day, first case on time starts will be monitored and will play a role in maintaining block time.
i. Surgeons are required to be in the hospital 15 minutes prior to in-room time and should notify the OR by calling if they are running late.
j. If a surgeon has three late starts in one quarter related to not being present 15 minutes prior to in room time, the surgeon will have the next quarter to correct his first case on time starts prior to block time being adjusted.
k. Outside of emergency and urgent add-ons, surgeons with block time must schedule and fill this time prior to being allowed to schedule in open time. Surgeons without block time are given priority in open time.
l. The Hybrid OR will be blocked for TAVRs and CTOs based upon necessity to do procedure. Block time is released one week prior. The Hybrid OR is blocked from 0800-1300 for vascular surgeon's on their normal block days outside of block time allocated for TAVRs and CTOs.
m. It is the responsibility of the block time owner to manage and release block time appropriately to ensure adequate utilization. It is the surgeon's responsibility to notify the OR scheduling office at least two weeks in advance when block time is not needed related to vacation or time off. Block time releases made two weeks prior to the surgery made are not counted against block time utilization.

6. The elective schedule is closed or reduced on:

EMERGENCY ONLY:	FOUR (4) ROOMS ONLY:
Thanksgiving	Friday after Thanksgiving
Christmas	
New Year's Day	
July 4th	
Labor Day	

C. CHS
1. Operating Rooms are available for scheduled elective procedures Monday-Friday 0800-1730.
a. Inpatients, a.m. admissions, and observations must have a bed reservation.
b. Cases may be scheduled beginning at 0800. A maximum of two 0700 cases may be scheduled with consideration given to preparation time and staffing availability.
c. One room is scheduled until 1530, one room is scheduled until 1730. If there is a need for an additional room until 1730, it is at the discretion of the Team Leader or designee.
d. Call the Surgery Desk (887-7458) for add-ons to the surgery schedule.

e. Only emergencies are done after the scheduled operating hours.

2. Authorized personnel enter scheduling requests into the computer.
   a. Surgery scheduling is open Monday-Friday 0800 at 887-7770.
   b. Elective procedures should be scheduled by 1700 the day preceding surgery.
   c. Requests are accepted only from the physician or personnel employed by the physician.
   d. Weekdays and holidays - requests for scheduling on the day following are accepted by the call coordinator.
      1) Reservations are subject to all regular criteria.
      2) Confirmation and/or denial of request are communicated to the physician on the morning of surgery.
3. Block scheduling guidelines
   a. Type of scheduling is a combination of block and open.
   b. Block requests are considered on the basis of utilization. Specialty blocks are given based on the percentage of total procedures.
   c. Release of the block 48 hours to 7 days (exception: due to having one da Vinci robot, block time in that room are released two weeks from the day of the procedure). Release of block time is negotiated with the physician and is based on the percentage of utilization.
   d. Block utilization is evaluated and discussed with physician.
   e. Adjustments in blocks may be necessary if utilization percentage is below 60% or above 85%.

D. CHVH
   1. With the exception of the holidays, the OR is staffed ten (10) hours a day, five (5) days a week. After hours and emergency cases are staffed with on-call staff as needed. Holidays are covered by a designated on-call team. Recognized holidays include:

New Year's Day	Memorial Day
Fourth of July	Labor Day
Thanksgiving	Christmas

   A reduction in available ORs for scheduling may occur New Year's Eve, the day after Thanksgiving, Christmas Eve, the week between Christmas and New Years and the week of spring break(s).
   2. Cases may be scheduled Monday through Friday between 0800-1700. Scheduling requests outside of these times is determined on a case by case basis. Only emergencies and urgent cases are done after the scheduled OR hours.
   3. Surgery schedules are closed/published Monday through Friday at 1630. Any request outside of this time is treated as an add-on.
   4. Availability of time on the OR schedule is determined by:
      a. Type of anesthesia required
      b. Availability of nursing staff
      c. Availability of supplies and equipment (ie: TEE, laser, x-ray)
      d. Length of time needed for procedure, including set-up time, operating time and clean up time.

5. To schedule a case call the **Scheduling Office at** between 0700 and 1700. After these hours the scheduling line is forwarded to the House Supervisor to handle requests for add on/urgent or emergent procedures.
6. Scheduling requests may also be submitted via fax at
7. All requested information must be provided to the surgery scheduler prior to the surgery being placed on the schedule. Information necessary to put a case on the schedule includes, but is not limited to:
    b. Date and time requested
    c. Surgeon's name
    d. Type of anesthesia
    e. Procedure to be performed
    f. Patient's name, phone number, and date of birth, and social security number
    g. Length of time needed
    i. We reserve the right to alter surgeon requested time based on historical case data.
    h. Special supplies or equipment needed
    i. Patient status
    i. Inpatients, AM admissions, and outpatients must have a bed reservation
    ii. Patients cannot be placed on the schedule in an 'observation' status. CMS dictates that an observation status may only be deemed necessary after the procedure has occurred and the patient's status at that time warrants observation.
    iii. The patient status of a Medicare patient is governed by Medicare's Inpatient Only List. When scheduling Medicare patients as an outpatient, be prepared to share the predicted CPT code. Scheduling personnel will check this CPT code against the Inpatient Only List. If the CPT code is on this list, the patient must be scheduled and treated as an inpatient.

2. Surgery Waiting List (CHE & CHN)
    A. When a surgeon calls to schedule a case and there is no time available, the scheduling coordinator:
        1. Attempts to open another room subject to:
            a. Equipment/supplies needed.
            b. OR staff availability.
            c. Anesthesia availability.
        2. Offers to place the physician/procedure on a waiting list.
    B. If there is a cancellation or change in schedule:
        1. Scheduled cases are offered earlier times first at the discretion of the Medical Director and/or Team Leader or designee.
        2. Then the first surgeon on the waiting list is called and offered the time. If he declines, he is bypassed and the next surgeon is called.

3. Scheduling add-ons are on a first come, first serve basis.
    A. Anticipated start times are identified when the procedure is scheduled.
    B. Surgeons are to be notified as soon as possible if the start time may be delayed.

C. Should a surgeon be unable to move up when requested, that time may be filled with another procedure of similar length.
D. No substitution of patient names or unrelated procedure is accepted.
E. The above referenced patient information is required at the time of scheduling from the physician or the physician's office. The surgery may not be scheduled with only a patient name.

4. Urgent/Add-On and Emergency Surgery, Regular Working Hours
   A. Urgent/add-on and emergency procedures are accommodated on a first come, first serve basis subject to the nature of the patient's condition.
   B. The surgeon notifies CHE Surgery ; CHN , CHS
      a. Patient procedure information is recorded, and includes those items mentioned above.
   C. The secretary, Team Leader, Clinical Director, or designee:
      a. Notifies the anesthesiologist and rearrange the schedule as needed.
      b. Contacts the surgeon to confirm surgery start time.
      c. Notifies POCU to change pre-op medication times or to delay sending for a scheduled patient.

5. Emergency Surgery, Non-working Hours
   A. CHE has staff cover phone calls 7 days a week, 24 hours a day.
      a. The Emergency Department, or the surgeon, calls the main OR at 355-5959 to schedule the procedure.

   B. CHN
      a. CHN OR has in-house staff 24 hours a day, 7 days a week. Exception: Holidays are covered by a designated On-Call Team. There is always available a total of two (2) OR people on weeknights and three (3) OR people on weekends and holidays if needed.
         1.) The surgeon calls) to speak with a staff person to schedule the procedure.
         2.) The staff person calls/pages the "1st call" anesthesiologist.
         3.) When the "1st call" anesthesiologist returns the call, the CHN OR staff person relays the case information to the anesthesiologist. The anesthesiologist confirms the start time.
         4.) The staff person returns the call to the surgeon to verify the start time.
         5.) The staff person notifies the "on call" team of the emergency/urgent case.
         6.) If necessary, the first on-call staff person arriving for duty obtains the OR keys.

   C. CHS
      A. During non-working hours, emergency surgery is staffed by a designated on-call team. The hospital operator has the on call roster.
      B. The surgeon notifies the call coordinator that he/she has an emergency to schedule.
      C. The call coordinator:
         a. Requests the patient/procedure information.
         b. Notifies the on-call anesthesiologist and surgery team.

   D. CHVH

After Hours (after 5 pm Monday – Friday) and Holidays

a. The surgeon calls 621-8950 and speaks with the on-call coordinator to schedule the procedure
b. The anesthesiologist on-call is contacted by the on-call coordinator with case information, which includes the estimated/requested start time.
c. The on-call coordinator then alerts the House Supervisor to contact the "on-call" team of the emergency case.

Weekends

a. Weekends are reserved for the scheduling of urgent/emergent cases.
b. Every effort should be made to do cases M – F.

6. Advance Notification of emergency surgical procedures to be performed on Saturday, Sunday or holidays.

A. CHE has staff cover phone calls 7 days a week 24 hours a day. Therefore, staff is made aware of the scheduled procedures.

B. CHN

1. Surgical procedures that are to be performed may be scheduled beginning at 0700 24 hours prior to the weekend/holiday.
2. Calling eaches an OR staff person as this number is forwarded to the charge nurse phone after the scheduler is off duty.
4. All necessary staff are made aware of the case so it can start on time.

C. CHS

1. Surgical procedures that are to be performed on Saturday, Sunday or holidays are scheduled beginning at 0800 24 hours prior to the day of surgery.
   a. An anticipated start time may be given subject to earlier requests, emergencies and/or anesthesia availability.
2. Friday- 0800-1700 the scheduling service accepts requests at for weekend cases. After 1700, call the surgery department at o schedule a procedure. The OR call coordinator can be reached by calling the hospital operator if staff have completed their shifts and are gone for the day.
3. If the OR and PACU on-call are aware of the procedures, the call coordinator does not call the team unless there has been a change.

CHVH

Management of the Daily Schedule

1. It is a team effort to start surgery on time and all participants of the OR team (including physicians) are held accountable to ensure timely starts.
   a. Anesthesia assesses the patient no later than 15 minutes prior to in room time.
   b. Peripheral vascular surgeons are present 15 minutes prior to in room time.
   c. Cardiovascular surgeons are present 15 minutes prior to in room time.

   d. OR staff are to have surgical patients in the room no later than five (5) minutes of scheduled in room time.
2. Except in emergency situations, patients are not transferred to the OR until all team members are present and required documentation is complete. Required documentation consists of:
   a. Complete history and physical that has been appropriately updated the day of surgery.
   b. Signed surgery and anesthesia consents
   c. Signature indicating Informed Consent by the physician
   d. Completion of surgical site marking if appropriate

   If a physician consistently fails to meet requirements, it could result in penalties such as loss of Block Time, inability to schedule, etc.
3. In the event of delays, the operating room staff proactively notify surgeon by placing calls or paging to communicate as soon as possible. An indication of the estimated length of time before the procedure can begin is given.
4. The charge nurse and the anesthesiologist in charge will collaboratively be responsible for adjusting time frames due to cancellations, delays or any unexpected time openings. Elective cases have priority for completion over add on cases, however, facilitating the completion of the schedule in a timely efficient manner is taken into consideration.

Documentation Guidelines: None

References: None

Approved by:	Perioperative NPP Subcommittee	Date: 6/2014
	Clinical Director Surgical Services, CHE	Date: 6/2014
	Clinical Director Surgical Services, CHS	Date: 6/2014
	Clinical Director Surgical Services, CHN	Date: 6/2014
	Director, CVOR	Date: 6/2014
	Medical Director, Anesthesia, CHE	Date: 6/2014
	Medical Director, Anesthesia, CHS	Date: 6/2014
	Medical Director, Anesthesia, CHN	Date: 6/2014
	Medical Director, Anesthesia CHVH	
	Risk Management	Date: 6/2014
	Infection Prevention	Date: 6/2014
Approved:	NPP Steering Committee	Date: 6/11/2014

UNIT PROTOCOL

TITLE: CALL GUIDELINES

The call guidelines for CHS Surgery Department are subject to change as deemed necessary by the Team Leader and Surgery Coordinator to cover any unusual circumstances (i.e. MLOA, resignations, new hires, etc.)

CALL RESPONSIBILTIES

1. It is each employee's responsibility to be available for their assigned call at the end of their shift. On an employee's day off, call hours begin at 1530. Failure to be available when on call is to be documented on an incident report and to be reported to the Team Leader for further action.

2. It is each employee's responsibility to notify the Call Coordinator of where and how he/she can be reached if he/she is not at home. Also, it is the responsibility of the employee to make sure that his/her pager is on and in working order.

3. Each call crew should consist of an anesthesiologist, pre-op/recovery nurse, a circulator and a scrub. The circulator must be an RN. Most cases will require two scrubs. This decision is at the discretion of the Call Coordinator.

4. Tech's and RN's will both be assigned call.

5. On call personnel need to be able to reach the hospital within 30 minutes during on call hours.

6. In the event of an IOPO case, the Call Coordinator will be required to come in. Call one and Call two employees are only required to come in if IOPO is doing a live harvest and will need an anesthesiologist.

7. In the event of an endoscopy case, only one registered nurse should come in to assist anesthesia, as both the endoscopy call nurses will be

8. there. (ie: If Call One is a CST, and Call Two is an RN, Call Two will be required to come in. If Call One and Two are CST's, then the Call Coordinator will be required to come in).

CALL COMPENSATION

1. Stipend pay is $5 per hour. Stipend pay remains in effect even during the call hours that are being worked.

2. The current pay rate if you are called in is time and one half your hourly rate.

3. Each employee is allowed one four-hour minimum per shift (Shifts are as follows 0700-1500, 1500-2300, and 2300-0700). You are guaranteed 4 hours of pay at time and one half your hourly rate if you are called in, even if you were here for a shorter period of time. After the four-hour minimum, you are paid time and one half your hourly rate for the hours worked, unless you are called in during a different shift.

4. Employees that share call hours must split the four-hour minimum if relieved during a case. Otherwise, each employee is still eligible for one four-hour minimum per shift, even if the call hours are being shared amongst them.

5. You are eligible for evening and weekend premiums if you are called during those shifts. Holidays are equal to weekend shifts.

6. There is no limit to the amount of call anyone takes after a fair distribution of the available call hours is dispersed. However, should excess call hours interfere with regular duties, and is documented by co-workers and/or management, steps will be taken to correct the situation.

CALL COORDINATOR RESPONSIBILTIES

1. The Call Coordinator will be an approved RN who has shown leadership capabilities within the department.

2. The Call Coordinator will take call for a one-week period of time.

3. The Call Coordinator will be the first contact from the surgeon, ER, anesthesia, or ancillary staff to schedule a procedure.

4. The Call Coordinator will be responsible to call the OR crew as needed in a timely manner.

5. The Call Coordinator will be a resource person for those on duty or on regular call.

6. Stipend pay is the same as regular call, $5.00 per hour.

HOLIDAY CALL

1. Holidays are: Memorial Day, July 4th, Labor Day, Thanksgiving, Christmas Day, and New Year's Day. Easter, Christmas Eve, and New Year's Eve are not paid holidays.

2. Holiday rate is paid on the day our department is off for the holiday. This is not necessarily the same day as the actual holiday.

3. Holidays are signed up for once a year. The Team Leader makes the decision regarding how employees will sign up for holiday call.

4. It is each employee's responsibility to sign up for approximately three holiday call dates/times.

REGULAR CALL ASSIGNMENTS

1. Weekday call is Monday through Thursday. Weekend call is Friday

2. through Sunday. (The weekend stipend starts at 12:01 AM Saturday).

3. Monday through Friday call starts at the end of each employees shift, or at 1530 if it is his/her day off, and call ends at 0700 the following morning. Weekend call starts at 0700 Saturday and/or Sunday, and ends the following morning at 0700.

4. Each employee is off call at 0700 the following morning, and all efforts must be made to relieve him/her. If an employee is able to stay, it is greatly appreciated, yet, it should not be taken for granted.

5. Each employee must sign up for his/her own assigned number of call days. Call will be as evenly distributed as possible by the Team Leader.

6. Each employee will sign up for call according to a rotating roster each schedule.

7. If "extra call" is desired, there will be a box on the schedule that can be checked. "Extra call" will be distributed according to that schedule's sign up rotation.

8. If you do not want to take or are unable to fulfill your assigned call, you should circle your call date(s). Your call will be divided equally amongst the employees wanting "extra call." If for any reason your call is not covered, you are then responsible to take the call.

9. Only the Team Leader or Surgery Coordinator can make approved changes on the call schedule.

NEW EMPLOYEE CALL

1. A new employee can take "buddy call" once the Team Leader, the Surgery Coordinator, and his/her preceptor decides that he/she is ready.

Updated July 22, 2004

2. There is no limit to the amount of "buddy call" that an employee can take, as long as the Team Leader decides it is not detrimental to that employee's learning.

3. There will be mandatory call for new employees for the first 3 months post orientation. This call may be traded, yet, cannot be given away.

4. The new employee should make sure to sign up for call on a night that an experienced employee is on call.

Updated July 22, 2004

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 10/16/08

NPP#: ENDO: C-01
Page 1 of 2
EFFECTIVE: 4/30/13

TITLE: ON CALL GUIDELINES

Performed by: RN, LPN

Purpose: To establish on call guidelines.

Policy Statements:
Physicians needing to perform emergency GI procedures after normal business hours will follow established guidelines for each Endoscopy Department.

General Information: None

Equipment: None

Procedure:
NORTH:
1. Hours of on call nurses: Monday-Friday 1700-0630, and weekends/holidays 0700-0700.
2. One Endoscopy trained RN will be on call at all times.
3. Physicians should contact the hospital operator at , giving them specific information concerning the case (e.g., procedure to be done, equipment needed, type of scope).
   a. The operator will contact the on call nurse listed on the Endoscopy on call schedule. One Endoscopy trained nurse will be called in for surgery, emergency room, and critical care cases. The second person for the procedure will be a registered nurse from the respective unit acting as the monitoring RN.
   b. A second Endoscopy trained nurse will be on call weekends and holidays from 0800 – 1200.
   c. Physicians may call the on call nurses directly if preferred.
4. Emergency procedures will be performed in the Emergency Department, Radiology, Operating Rooms and Intensive Care. Inpatients will be done in the Endoscopy Department on holidays and weekends from 0800 – 1200.
5. Endoscopy staff has 45 minutes travel time. The procedure will begin as soon as possible after that time.

East:
1. On call staff will be available after hours as follows:
   a. Monday through Friday after 1700 – one Endoscopy trained nurse available for emergent cases performed at the bedside in selected areas with the assistance of the bedside RN.
   b. Weekends and hospital designated holidays – one Endoscopy trained nurse 0700 – 0700, with second on call nurse available during 4-hour period 0800-1200 each day. Second on call nurse is available to assist with medical patients who meet the established criteria and can be done in the Endoscopy Department.
2. On call staff can be contacted through the hospital switchboard at Staff will be paged by the operator. Patient and case information must be communicated personally by the physician, to the on call staff member , as this will ensure that staff has all the information needed to prepare for the case.
3. On call staff has 45 minutes' travel time and will begin setting up the cases immediately upon arrival.

South:
1. Hours of "On Call"

   a. Weekdays: one Endoscopy trained nurse will be on-call at all times depending on where the procedures are done. Call hours begin at the end of the employee's scheduled work hours.
   b. Weekends/Holidays: The Endoscopy Unit will have 24 hour coverage by Endoscopy personnel
2. Emergency procedures performed in the Endoscopy Department and the Emergency Department: the call one Endoscopy nurse will contact a second Endoscopy nurse until 2200; thereafter, the call two PACU nurse will cover call hours from 2200-0700.
3. Emergency procedures performed in the Intensive Care Unit and Progressive Care Unit will be staffed by an on call Endoscopy nurse and the unit nurse assigned to the patient.
4. Notification of Endoscopy On Call personnel.
   a. Physicians should contact the hospital operator after 1700 at 887-7000. The operator will page the on call Endoscopy nurse to call the physician.
   b. Physicians may call the on call Endoscopy nurse directly if preferred.
5. Staff has thirty minutes travel time. They will begin setting up the case immediately upon arrival.
6. As necessary, Endoscopy call staff will be utilized as back-up for PACU.

References: None.

Documentation Guidelines: None.

Approved by:	Infection Control	Date: 3/13
	Risk Management	Date: 3/13
	Endoscopy Subcommittee	Date: 3/13
Approved:	NPP Steering Committee	Date: 3/13/13

QUALITY/SAFETY MANAGEMENT PLAN
SURGICAL SERVICES

Community Hospital South
Community Hospital North
Community Hospital East
Community Hospital Anderson

July 2011

Index

I. Mission/Vision/Value Statements

Mission

The mission of Surgical Services is to be a leader in providing a full continuum of services to the community services by the Community Health Network. We will be central Indiana's most preferred inpatient and outpatient surgical service provider and we will deliver unsurpassed service to our physicians and their patients. In partnership with our medical staff, we offer innovative and individualized surgery options that are responsive to our customer's needs. We are committed to efficiently and safely delivering the highest quality surgical care, creating an exceptional experience for physicians, patients, families and employees.

Vision

It is the objective of Surgical Services to accomplish our Mission by partnering with physicians, patients, families and employees. We will benchmark performance indicators and major processes. We will creatively develop new approaches and alternative delivery systems offering state of the art technology for best demonstrated practices in surgical services. These continuous improvements will result in a system that will provide high quality services as evidence by total customer satisfaction.

Values

Patients First: We believe that patients' needs, and the needs of their families, are our number one priority.

Relationships: We are inclusive, working together as partners and teams.

Integrity: We expect truth-telling and transparency.

Innovation: We foster creativity and openness to new ideas.

Dedication: We are accountable stewards of the resources entrusted to us.

Excellence: We provide access to a high quality and safe environment of care, known for high performance.

Community's statement of values is all about making our organization the best it can be—providing the most exceptional experiences possible for patients and families, opening our doors to all who desire our services, building the health care workplace of choice for central Indiana, creating exceptional experiences for physicians, ensuring that our organization is

efficient and fiscally healthy. We can't succeed as a team unless we all live our values, which we remember with the acronym PRIIDE.

Business Growth

We strive to continually grow our business by creating the most surgeon-oriented surgical facilities in the Midwest. We provide our patients with the strongest blend of quality, service and price, making our facilities the customer's and payer's choice for surgical care.

Financial Performance

We focus on the delivering safe and cost-effective health care through efficient use of our resources.

II. Types and ages of patients served

Surgical Services provide services tailored to the special needs based on age: newborns (CHN), infants, children, adolescents, adults, and senior adults. Interventions are provided throughout the continuum with the exception of major organ transplantation.

III. Scope and complexity of need; extent to which needs are met

Services are designed for all levels across the health continuum. Services include education and consultation from pre-procedure planning to discharge follow-up.

The continuum of care is comprehensive and includes but not limited to:

- Community Support
- Consultation
- Education
- Home Health
- Inpatient
- Outpatient
- Pre-Operative Clinic
- Wellness

Unit Description

CHE	6	Surgery Suites
	2	Procedure Suites
	6	PACU surgical beds (to include one isolation bed)
	6	Pre/Post-operative beds
	3	Endo beds
	1	Pre-op Clinic bed
CHN	8	Operating rooms approximately 650 square feet each
	9	Minor procedural care unit with 9 procedure rooms: ECTs

	15	Private pre-operative rooms (2 of which can function as PACU bays if necessary)
	6	Dedicated PACU bays (total of 8 if utilizing 2 pre-op rooms noted above)
	2	2 of the above 23 rooms able to care for isolation patients
	1	Assisted fertility laboratory
		Post-operative care beds
CHS	6	Surgery suites
	9	PACU I beds (to include one isolation bed)
	17	Pre/post beds (includes 1 isolation bed)
CHA	6	Surgery Suites
	9	Special procedures suites
	1	Mobile lithotripsy unit
	1	OB C-Section suite
	18	Pre/post-op beds (includes 1 isolation bed) (* also called extended recovery or PACU II)
	6	Pre/post-op lounge chairs
	8	PACU I surgical beds

Surgical inpatient units (pre/post procedure care)

Each patient's need for nursing is assessed by a Registered Nurse at the time of admission with a complete health assessment including physical, psychological, self-care, educational and environmental factors relating to discharge planning per policy. When necessary and appropriate, data is obtained from the patient's significant other and/or family and is included in the assessment. Aspects of data collection may be delegated by the RN to a Licenses Practical Nurse, Clinical Technician, Patient Support Partner, or a Student Nurse Extern. Reassessment of the patient's condition occurs at least every eight hours by an RN or more frequently based on changes in the patient's condition.

A care manager is designated on admission and is accountable for planning the care throughout the hospital stay using patient care pathways and multi-disciplinary team members such as Clinical Nurse Specialists, Social Services, Utilization Review/Case Managers and Physicians. The plan of care is made with input from the patient and/or significant other to provide quality patient focused care. Patient/families education is completed based on assessed needs and reinforced prior to discharge. How well we meet patient's needs and expectations is measured through patient satisfaction surveys and appropriate referrals made as necessary.

Observation Unit

This unit provides care for post surgical/procedural patients as well as medical patients.

Each patient's need for nursing care is assessed by an RN at the time of admission with a complete health assessment including physical, psychosocial, self-care, educational and environmental factors relating to discharge planning per policy. When necessary and appropriate, data is obtained from the patient's significant other and/or family and is included in the assessment. Aspects of data collection may be delegated by the RN to an LPN, Clinical Technician, or a Student Nurse Extern. Reassessment of the patient's condition occurs at leader every eight hours by an RN or more frequently based on changes in the patient's condition.

The RN is accountable for planning the care throughout the observation stay using patient care pathways and multi-disciplinary team members such as Clinical Nurse Specialists, Social Services, Utilization Review/Case Managers and Physicians. The plan of care is made with input from the patient and/or significant other to provide quality patient focused care. Patient/families education is completed based on assessed needs and reinforced prior to discharge. How well we meet patient's needs and expectations is measured through patient satisfaction surveys and appropriate referrals made as necessary.

Pre-op Clinic

The pre-operative clinic offers pre-admission testing/screening and education for patients 2-3 weeks prior to their surgical procedure. Patients can be seen by an anesthesiologist or internal medicine physician via surgical referral. Patient seen by an anesthesiologist is based on ASA rating; ASA 3-4 are automatically seen by an anesthesiologist. One hour clinic appointments can be made through Centralized Scheduling at . and can be scheduled from 8:00 a.m. – 3:30 p.m. Monday through Friday, according to needs of specific sites. Internal medicine clinics are scheduled from 12:00 p.m. – 5:00 p.m. Monday, Tuesday, Wednesday at CHS. These appointments can be made via Centralized Scheduling or by calling a clinic nurse at . Pre-op clinics at CHE can be scheduled from 9:00 a.m. – 2:00 p.m. Monday and Wednesday. Same day appointments at CHN may be made at . Special arrangements may be made outside of this time if needed.

Surgery pre-procedure area

The RN receives and admits the patient to the unit. The patient is initially identified using at least two patient identifiers. The RN performs and assessment on each patient who is admitted through this unit. This assessment includes the identification of the patient's physician, psychosocial, spiritual and economic needs. The RN also obtains a complete health history by utilizing advanced interview techniques, including open-ended questions to gather data. Labs, x-rays, EKG and other tests are ordered based on direction from the Surgeon, Endoscopist and/or Anesthesiologist/physician. All verbal and/or telephone orders are verified by the RN utilizing the RAV read-back and verify) system. Pre-procedure teaching is done by the RN with the patient, and/or family/significant other. The site verification process with the surgeon is initiated here with involvement of the patient and family or significant other. This educational component includes, but is not limited to, the process that is utilized to ensure the patient's safety, such as repetitive questioning regarding allergies, type of procedure, and patient cart rails in place. The patient is apprised of what

can be expected from the Anesthesiologist/physician such as meeting him/her pre-procedure, having an IV started (if not already in place), and the process of anesthesia sedation. The patient is also educated regarding the stay in the PACU if appropriate. The RN discusses the discharge instruction sheet and reinforces those areas that are specific to the patient and his/her procedure. Although there is a basic teaching plan in place, education is individualized to address those previously assessed needs. The patient acknowledges problems that are identified and addressed by the RN pre-procedure. These potential problems include but are not limited to the need for crutches or walker, lack of a ride home, or lack of a responsible person to stay with the patient at home.

Pre-procedure medications are administered and IV fluids are initiated by the RN/LPN as ordered by the Anesthesiologist and/or Surgeon. The RN/LPN ensures that consent for the procedure has been obtained prior to administering pre-operative medication to the patient. Any relevant information regarding a patient's special needs is communicated verbally to the Operating Room RN and PACU RN utilizing the "hand-off" approach in addition to documentation of the same.

A systems approach is utilized when the RN performs the assessment of a patient prior to a procedure. Baseline vital signs, including temperature, pulse, respiration, pulse oximetry, and blood pressure measurement are obtained. Cardiac monitoring is available as necessary. A re-assessment is performed as deemed necessary by the RN based on subjective and objective data. An RN is always in attendance/available when a patient is present in the unit.

Surgery

All patients undergoing a surgical procedure are assigned a minimum of one circulating registered nurse and one scrubbing registered nurse or certified/surgical technician. Additional circulators and scrubs are provided based upon the acuity/complexity of the procedure, physician request, and/or use of special equipment such as a laser. The site verification process continues with the "time-out" taking place with the entire surgical team involved by active communication. AORN Recommended Standards will be utilized as guidelines for safe optimal staffing and practice within the operating room setting. A Board Certified or Board Eligible Anesthesiologist provides all anesthetics within the surgery setting. All sites provide 24-hour staffing coverage. At CHS staff are on-site staff from 7:00 a.m. – 6:30 p.m. Monday through Friday. At CHE staff are on-site from 7:00 a.m – 7:30 p.m. Monday through Friday. At CHN staff are on-site 24-hours a day, 7 days a week. Exact times for scheduled procedures vary slightly by site. Add-on cases are performed on a case-by-case basis based upon the current surgery schedule at the time of request. After hours and emergency services are provided by on-call teams.

PACU I

Our Handoff Communication Process is continued at this time. The PACU RN receives a verbal report from the Anesthesiologist and Circulator as she/he accepts responsibilities for the patient's care. The RN performs an initial assessment and documents the findings. The assessment includes, but is not limited to, patency of airway, respiratory rate and depth,

blood pressure readings, condition and color of skin, patient safety needs, neuromuscular status, presence and condition or drainage tubes and catheters, dressing on operative sites, location and condition of IV sites and lines, assessment and documentation of input and output, Aldretti type score, and level of emotional and physical support needed. This assessment is ongoing during the patient's PACU care. The RN re-assesses the patient every 15 minutes during PACU care, but may perform a re-assessment more frequently if condition warrants. All RNs delivering care are ACLS certified. At CHN all RNs are required to be PALS certified due to the pediatric population.

A certain level of competence is required by all RNs delivering this care, therefore each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient's classification, each patient receives care on the basis of assessment of needs.

Re-assessments are performed with any changes in condition, cardiac rhythm and post-invasive procedure. The data obtained is interpreted and documented by the RN. Nursing actions and/or interventions with outcomes are documented. The RN collaborates with the Anesthesiologist and/or Surgeon as appropriate. All orders are read-back and verified with the ordering physician.

The same standard of post-anesthesia care is provided to ICU patients whether in the PACU or in the ICU, based on Anesthesiologist's orders. The care is provided by ICU RNs who have been cross-trained. At CHA patients who return to ICU from the OR are recovered by the PACU RN for the first hour.

When a patient has met discharge criteria, but their bed is unavailable, re-assessments and vital signs will be completed every thirty minutes.

Those patients whose total care requires expertise and resources that are unavailable at CHI will be stabilized, treated, and transferred to the appropriate facilities.

Post-Op/Phase II

This area is a step-down unit from the Phase I unit. Patients are taken to this unit to recover prior to discharge. Patients who have received only local or IV sedation are generally taken here directly from the procedure room. At CHN and CHS Phase I and Phase II levels of care and not separate areas, the care to the patient is provided in the same room. There is no physical movement of the patient between levels of care. Families are able to join the patients during Phase II level of care. Discharge instructions are reinforced with patient and family by the RN and a written and/or electronic copy is sent home with patient.

A complete assessment utilizing a systems approach is performed by the RN on each patient upon admission to PACU II and prior to discharge utilizing the hand off communication again. Re-assessments are done as necessary with any change in condition or previously assessed parameters. Cardiac monitoring and pulse oximetry capabilities are available if necessary. If a patient's condition warrants, he/she will be transferred to PACU I.

Home Care

- Involved with continuum of pathway
- Referred to appropriate home care specialist
- Involve hospital Social Services as necessary
- Special needs are met by referral to specialty personnel, i.e. ostomy care, education, and physical therapy for crutch and/or walker training.

IV. Appropriateness, clinical necessity and timeliness of support services provided directly by the organization or through referral contacts

Surgical services are provided by a multi-disciplinary professional staff which includes but not limited to: Primary Care Physicians, Surgeons, Anesthesiologists, Physician Assistants, Nurses, Certified Surgical Technologists and internal and external Case Managers. Ancillary Surgical Services staff includes: Student Nurse Externs, Clinical Technicians, Certified Surgical Technologist Students and volunteers. In addition, clinical support is provided by: Respiratory Care, Pharmacy, Radiology, Laboratory, Nutrition, Physical Therapy, Social and General Services, Materials Management, Finance and Information Systems as needed in a timely manner.

The administrative staff for Surgical Services includes: the Executive Director, Medical Directors, Team Leaders, Clinical Directors, a Financial Consultant and a Human Resource representative.

V. Availability of necessary staff

Surgical Inpatient Unit (pre and post operative care)

Care delivery is provided by using a Care Team Model and the master staffing plan. Assignments are based on the following elements:

- Continuity of nursing staff assigned
- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff.
- Consideration of relevant Infection Control and Safety issues.

To ensure availability of adequate staff the following mechanisms are in place:

- Twenty four hour leadership accountability
- Centralized Scheduling (Pre-Op Clinic)
- Human Resources
- Network Float policies

Observation Unit

Care delivery is provided using the master staffing plan. Assignments are based on the following elements:

- Complexity of patient condition
- Dynamics of patient acuity level
- Type of technology required to provide nursing care
- Competency level and degree of supervision required by staff
- Availability of supervision in relation to the assessed and current competency level of staff
- Consideration of relevant Infection Control and Safety issues

To ensure availability of adequate staff the following mechanisms are in place:

- Centralized Scheduling
- Human Resources
- Network Float Policies

Surgery pre-procedure area

A modified Primary Nursing model for delivery of care is utilized in the pre-procedure care unit. The RNs are cross-trained to work in the admission, procedure and recovery areas. All required to maintain a level of competence. The RN is competent to admit, assess and administer care to a pre-procedure patient of any level of acuity or complexity. The LPN is required to maintain competency to administer care to a pre-procedure patient of any level of acuity or complexity under the direction of an RN. If the patient's identified needs require more nursing resources and additional RN/LPN is utilized to assist. Support personnel are available to assist the RN/LPN. This unit is routinely staffed by RNs Monday through Friday at:

- CHE, 6:00a.m. – 5:00p.m.
- CHN, 5:00a.m. – 9:30p.m.
- CHS, 6:00a.m. – 7:30p.m.
- CHA, 7:00a.m. – 5:00p.m.

Surgery

All procedures are assigned a minimum of one monitoring/circulating RN. Demands of each procedure room schedule will be optimally matched with skills and expertise of assigned competent staff. Assignment of additional personnel will be provided as necessary with consideration to:

- Need for hospital scrub, RN, CST
- Acuity/complexity or procedure
- Physician request
- Special equipment, i.e. laser

One credentialed laser nurse will be assigned to each laser procedure with exclusive responsibility to laser operations the exception being laser ophthalmic procedures. General anesthesia services are provided by Anesthesiologists. The surgical area is open for routine procedures from 7:00a.m.–6:30p.m. Monday through Friday, at CHA 7:30a.m. – 6p.m. Outside of normal working hours emergency coverage is provided by on-call terms.

PACU (Phase I)

PACU I utilizes a modified Primary Nursing model for delivery of care. With this model an RN takes primary responsibility for assessing and addressing a specific patient's needs during his/her stay in the PACU. A Charge Nurse is assigned on a daily basis to coordinate care and activities. Primary care is delivered by an RN. All PACU RNs are ACLS certified with re-certification completed biannually.

A certain level of competence is required by all RNs in the PACU, therefore, each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient classification, each patient receives care on the basis of assessment of needs. Clinical technicians assist with designated duties under the directions of the RN. This unit is routinely staffed Monday through Friday at:

- CHE, 6:00a.m. – 10:00p.m.
- CHN, 5:00a.m. – 6:00p.m.
- CHS, 8:00a.m – 7:30p.m.
- CHA, 7:00a.m. – 6:00p.m.

Outside of working hours care is provided by on-call teams.

PACU (Phase II)

PACU II utilizes a modified Primary Nursing model that also represents the care delivery system in PACU I. All RNs are required to maintain a level of competence to provide care to a patient of any level of acuity or complexity. Support personnel are available to assist the RN. Assignment of care is based individually on the assessed patient needs. The unit is routinely staffed for surgery 8:00a.m. – 9:00p.m. Monday through Friday at CHE and 6:00a.m-10:30p.m Monday through Friday at CHN. Hours of operation at CHS for surgery are 6:00a.m. – 7:30p.m. Monday through Friday. At CHA hours of operation are 6:00a.m. – 10:00p.m. Outside of normal working hours care is provided by on-call teams.

VI. Standards/Guidelines for Surgical Services Practice

Standards and Guidelines for Practice are utilized to provide care and include but are not limited to the following:

- Patient Care Pathways
- Professional Practice Model
- Patient Rights Handbook
- Advanced Practice Committee Guidelines/Recommendations
- Unit based guidelines for patient care that include:
    - ASPAN

- AORN
- SGNA

- Hospital Policy and Procedure
- External Licensing Regulations and Accrediting Body Standards

VII. Methods to assess and meet patient needs

- Nursing process
- Admission assessment forms
- Risk screens/pre-admission clinic
- Pathway implementation
- Patient satisfaction surveys
- Follow-up phone calls
- Cost comparisons
- LOS comparisons
- Outpatient admission rates
- Review scope of care (III and IV)

VIII. Identification of MAJOR internal and MAJOR external customers

Internal

- Employees
- Physician
- Other Departments

External

- Payer/employers
- Patients/significant others
- Community at large
- Physician offices

IX. Patient/significant other education

Teaching Protocol

This education will be age specific to include the following:

- Patient rights and responsibilities
- Estimated or schedule time for surgery/procedure
- Monitors to be utilized patient identification protocol
- Anesthesia related teaching by appropriate professionals, i.e. Registered Nurse, Anesthesiologist
- Explanation of peri-operative environment and safety procedures
- Post procedure destination
- Usual recovery time with exceptions and patient/family participation expectations
- Time and location family/significant other may resume visitation
- Assurance that needs will be met, i.e. warm blankets, pain relief and antiemetic therapy

- Possibility of O_2 therapy per their need
- Instruction of pain scale 0 – 10
- Validation of understanding patient/family/significant other of education with documentation
- All other educational needs will be individualized as needed per specific procedure, i.e. SCDs, PCAs, crutch training and drains
- All education is reinforced to patient, family and significant other prior to discharge and documented on appropriate from per unit protocol

See Scope of Care (III and IV for individualized unit patient education)

Education Tools

- Videos
- Pathways
- Tours
- Handouts

Home Care

- Education built into pathway

Surgical Services patient follow-up

- Outpatient procedures will receive a follow-up phone call within 24-48 hours of working business days. This will give the patient customer opportunity to voice questions, allow reinforcement of physician direction and identify satisfaction as well as opportunities for improvement.
- A letter will be sent to those outpatients who are not reached 24-48 hours of working business days post procedure by phone after 2 attempts.
- Opportunities for improvement are specifically identified through patient satisfaction questionnaires.

Plan Formulated By: _____

_____

_____

_____

Approved by: _____ Date: _____

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Approved by: _____ Date: _____

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/2013

NPP#: ORSPP: P-02
Page 1 of 2
EFFECTIVE: 6/13/13

TITLE: **Pre-operative PROTOCOLS FOR THE REGISTERED NURSE**

Performed by: RN Caring for patient scheduled for an Operative Procedure

Purpose: To provide pre-operative care direction via protocols for the Registered Nurse (RN) providing Care to the patient scheduled for an operative procedure

Policy Statements:
1. The protocols listed in this policy are specific to OPERATIVE procedures and may be initiated by the RN prior to a scheduled procedure. THESE PROTOCOLS DO NOT APPLY TO ANY PATIENT OUTSIDE OF THE OPERATIVE/SURGICAL AREA.
2. Each protocol requires a medical order to initiate the pre-operative protocol. The protocol selected will be the protocol that matches the type of procedure scheduled. The RN may delegate specific tasks from the protocol to other staff within their scope of practice.
3. RN's working in the preoperative area of care must complete competency verification on the process of initiating and implementing pre-operative protocols.
4. If a patient is scheduled for a procedure and the procedure is included in one of the attached lists, then the RN will initiate that pre-operative protocol for that specific procedure. (SEE ATTACHED LISTING OF PROTOCOLS). If pre-operative protocol is not on the list of approved protocols then the RN must contact the surgeon to have him/her enter Pre-operative orders.
5. Pre-operative protocol orders will be initiated for all patients unless there are specific orders from the physician to not initiate the protocol order set. See listing of pre-operative protocols.
6. The RN must verify patient allergies prior to administering any medication.

General Information:
1. All orders entered for the pre-operative patient by protocol must be later cosigned by the procedural physician.
2. Additional information pertaining to specific procedures may be obtained from those specific procedure policies.

Equipment:
1. Order entry through Care Connect (select order entry, go to order set and select appropriate pre-operative protocol that matches the surgical procedure) and select ordered "as per protocol".

Procedure:
1. Initiate appropriate protocol based on the specific procedure that is scheduled.
2. Place the pre-operative orders by the using the approved associated operative protocol, on behalf of the procedural physician, who will later cosign these orders. The "Per Protocol" mode will be used for placement of these orders.
3. Monitor patient based on the protocol initiated, response to the protocol, and other physician orders.

Documentation Guidelines:
Document in Care Connect for Order Entry
Document Assessment on patient designated flow sheets within Care Connect
Document all medications on the electronic MAR

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 3/2013

NPP#: ORSPP: P-02
Page 2 of 2
EFFECTIVE: 6/13/13

Approved:	Dr. Michael Venturini	
Approved by:	Amy Glover Vice President Surgery and Surgery Services	Date: 3/14/13
Approved by:	Risk Management	Date: 4/10/13
	Infection Prevention:	Date: 4/10/13
Approved:	NPP Steering Committee	Date: 4/10/13

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 9/24/10

NPP#: P015A
Page 1 of 2
EFFECTIVE: 6/13/13

TITLE: SURGICAL/SPECIAL PROCEDURE CHECKLIST

Performed by: RN, LPN, PSP, PST,

Purpose: To provide guidelines for completion of the Surgical/Special Procedure Checklist.

Policy Statements:

1. Checklist must be completed on all patients having a surgical, endoscopic, or special procedure done (eg cardiac cath, coronary angioplasty procedure, etc). EXCEPTION: Bedside procedure.
2. Consent must be signed by patient or designee for surgery, endoscopy, cath lab or special procedure, prior to receiving any pre-operative sedation.
3. Isolation status must be noted.
4. Blood consent must be signed if T & C or T & S is ordered.
5. Vital signs, O_2 saturation must be taken no more than four hours before procedure, or administration of pre-op medication. (See NPP#: T-006, TPR). Vital signs must be documented in computerized patient record.
6. Pregnancy status is assessed on all fertile female patients prior to a surgical procedure scheduled with general anesthesia, IV sedation or regional anesthesia. Patients who have had a hysterectomy or are pre-menses or post menopausal are not tested. A patient may sign a "Waiver of Pregnancy Testing" to waive pregnancy testing. If waiver is signed, the surgeon and/or anesthesiologist are to be notified. For patients who have had a tubal ligation, a pregnancy test is required, or a waiver must be signed and recorded in the surgery checklist.
7. Consent for anesthesia is needed for any procedure requiring an anesthesiologist.
8. All allergies must be listed.
9. Armband and Allergy band must be placed on patient.
10. Last oral intake must be documented.
11. Ensure that IV site is functioning.
12. Body piercing jewelry is to be removed.
13. Surgical site needs to be clipped and marked by surgeon prior to leaving the pre-op area.

General Information:

1. Height and weight are needed by Anesthesia personnel to determine dosages on pre-op medications and anesthesia during Surgery. Obtain patient's weight on day of surgery.
2. If patient using tampons during menses, remove and apply peri-pad and disposable binder gauze stretch panties.
3. Patient to wear hospital gown only. Remove all under garments.
4. Anesthesia prefers all jewelry including body piercing jewelry be removed prior to surgery. If patient is unable to, or refuses to, remove any rings, cover stones with gauze and bands with tape/band-aid. Advise patient that ring may be cut off in surgery.
5. If patient does not have own contact lens case, a case may be obtained from CSR at CHE, CHN, CHS and from Emergency Room at CHVH.
6. If IV site is nonfunctioning notify the surgical team.
7. RN assesses need to obtain blood glucose level before patient leaves unit.
8. Complete appropriate department computerized or code white paper checklist.
9. Patient is transferred in bed or on cart with O2, if needed.
10. When paper form utilized: If surgery, endoscopy, or cath lab procedure is cancelled, write cancelled on checklist and retain with chart.
11. If there are any orders or instructions additional to the checklist, document addition as a note in computerized patient record or transcribe into Additional patient Information Section on Community Health Network Surgical/Special Procedures Checklist paper document.

12. In the event of a code white, complete the Community Health Network Surgical/Special Procedures Checklist N36 1009 ESI#5372 form that is printable and located in e-forms.

References: Internal Policy

Approved by:	Med/Surg NPP Committee	Date: 5/2013
	Infection Prevention	Date: 6/4/2013
	Risk Management	Date: 6/4/2013
Approved by :	NPP Steering Committee	Date: 6/12/13

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] TIHH
CANCELS: 9/17/09

NPP#: PACU: A03
Page 1 of 2
EFFECTIVE: 2/21/12

TITLE: ADMISSION TO SURGERY (PRE OPERATIVE CARE UNIT)

Performed by: RN, LPN, Surgical Technician

Purpose: To provide guidelines for the admission and preparation of a patient for surgical interventions performed in the OR Services Department.

Policy Statements:
1. This admission process is followed for outpatients, short stay patients, extended recovery patients, and AM admit patients.
2. The Perianesthesia Patient Care Pathway is initiated at the time of admission.
3. The patient will not be taken back to the surgery suite unless the H&P is available.
4. Refer to HIPAA Manual for policies of privacy and confidentiality.

General Information:
1. The surgeon's office notifies the surgery scheduling office of the date of surgery, time of surgery, planned operative procedure and desired anesthetic type.
2. The surgeon's office instructs the patient on arrival time and location, NPO status, pre-op medications, and miscellaneous instructions.
3. The surgeon provides the Pre Operative Care Unit with patient orders and history/physical data. If these are not available when the patient is admitted, the admitting RN contacts the surgeon for them.
4. The surgeon's office may send the patient to pre-register, obtain preoperative testing, or attend the Pre Op Clinic before the surgery date.
5. The admission assessment is recorded on either the Peri-Anesthesia patient Data Assessment Short Form, Admission Data Base- Surgery, or Admission Data Base-Pediatrics Form (refer to PACU: A-5). An RN may complete portions of the Admission Data Base prior to the patient's admission following the guidelines for clinic/telephoned patients. Use appropriate computer documentation where applicable.

Equipment: None

Procedure:
1. The patient registers at the specified facility and is directed to the Pre Operative Care Unit.
2. Welcome the patient, introduce yourself, establish patient identification, and apply the ID bracelet.
3. Verify transportation home if outpatient or extended recovery patient.
4. Initiate ordered preoperative testing (eg labs, ECG etc.) or locate results of pre-admission testing, review results, and place on patient chart.
5. Complete and document the patient assessment.
6. Instruct or assist patient to change into hospital attire.
7. Secure valuables as outlined in (ADM.F-005F) "Patient Valuables Procedures".
8. Verification checklist documentation initiated.
9. Briefly orient patient and significant others to the unit and the expected sequence of events for the day including teaching.
10. Relay patient information to the anesthesiologist, if one is scheduled for the procedure.
11. Review test results and relay any abnormal values to the physician.
12. Verify that the chart is complete and ready for surgery.

Documentation Guidelines:
Document on the Admission Data Base, Admission Assessment, Flow sheet, the Perianesthesia Patient Care Pathway, and any additional information in the Multidisciplinary notes. At Community Hospital North access the computer documentation. Document on the Admission Data Base, Admission Assessment, Flow sheet Pathway. Document any additional information in the Multidisciplinary Notes.

References:
ADM.F-005F "Patient Valuables Procedure"
CLN-2098, Surgery/Invasive Procedure Site Verification

Formulated by:	Perioperative NPP Committee	
Approved by:	Perioperative Policy/Procedure Committee	Date: 1/9/12
	Infection Control	Date: 1/11/12
	Risk Management	Date: 1/11/12
Approved:	NPP Steering Committee	Date: 1/11/12

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
APPROVED FOR: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 11/10/10

NPP#: C-048
Page 1 of 2
EFFECTIVE: 6/13/14

TITLE: CRITERIA FOR SENDING PATIENTS DIRECTLY FROM SURGERY TO CRITICAL CARE UNIT

Performed by: RN

Purpose:
1. To provide optimal safety for patients transferring directly from surgery to the critical care unit.
2. To identify patients appropriate for direct transfer to the critical care unit from surgery.
3. To identify the responsibilities of the patient caregivers when transferring a patient from surgery to the critical care unit.

Policy Statements:
1. After receiving notification, the person coordinating patient placement will work together with Surgical Services to determine the appropriate time for transfer as well as determining adequate time between multiple patients being transferred to the Critical Care Unit.

General Information:
Patient types appropriate for direct transfer to critical care from surgery include, but are not limited to, the following:
1. Patients sent to surgery from the critical care unit for a minor procedure, having received local anesthetic, IV sedation or regional anesthetic not expected to have a change in preoperative sensorium postoperatively.
   Examples: Patients who are comatose, intubated patients to OR for tracheostomy.
2. A patient whose medical/surgical condition is such that the anesthesiologist and primary care physician agree immediate return to the critical care unit is in the best interest of the patient. (Example: Patient is mechanically ventilated)

Equipment: Portable monitoring equipment and oxygen based upon patient condition.

Procedure:
1. Notify the critical care unit as soon as possible that the patient is a potential candidate for direct transfer/return to the Critical Unit.
2. Call the receiving nurse at least 30 minutes before the patient is transported to the unit.
   Report includes:
   A. Patient Name
   B. Surgeon
   C. Procedure
   D. Isolation status, if any
   E. Vital signs, hemodynamic status
   F. Location of peripheral IV's
   G. Pressure Lines
      1) Swan
      2) Arterial
   H. Drains
   I. Medication Drips (ie: dopamine, nitro etc.)
   J. I&O – including blood loss
   K. Ventilator settings
   L. Surgical/Medical complications
   M. Anesthesia
   N. Approximate time of arrival to the Critical Care Unit.

3. Surgical Services personnel monitor and transport the patient to the critical care unit, give report to the receiving nurse, and assist the receiving nurse as needed.
4. After transfer, Surgical Services personnel ensure family has been notified of the patient's transfer.

Documentation Guidelines: Document in patient's electronic medical record

Reviewed by:	PACU Staff/Critical Care Staff	Date: 6/2014
Approved by:	Peri-operative NPP Committee	Date: 6/2014
	Anesthesia CHN/CHE/CHS	Date: 6/2014
	Infection Prevention	Date: 6/2014
	Risk Management	Date: 6/2014
Approved:	NPP Steering Committee	Date: 6/11/2014

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] TIHH
CANCELS 1-23-09

CORP#: CLN-2098

EFFECTIVE: 4/19/12

TITLE: SURGERY/INVASIVE PROCEDURE SITE VERIFICATION/UNIVERSAL PROTOCOL

Purpose:
To provide the safest possible surgical and procedural care for all patients in Central Indiana by providing guidelines for the verification and documentation of correct patient identity, procedure, surgical site and time-outs.

Policy Statements:
1. All persons to be identified by two patient identifiers (name and date of birth).
2. All procedures in surgical and non-surgical/procedural settings, including bedside procedures will require surgery/invasive procedure site verification.
3. A physician will designate in the consent for surgery/invasive procedure order, the correct site of the procedure.
4. The physician, physician's order, history and physical, consent and schedule (if applicable) must all designate the same site.
5. The patient will sign consent for surgical and/or other treatment that is consistent with the physician's order. No abbreviations are permitted.
6. If there is a discrepancy among the schedule, the consent for surgical and/or other treatment, the physician's order, history and physical, the physician will be contacted immediately for clarification.
7. No patient or Perioperative personnel will be allowed to mark the site.
8. All patients will have the site of surgery identified by the physician on the day of surgery prior to being brought to the operating suite or procedural area.
9. The intent will remain to have every patient marked by the physician prior to the beginning of any surgery/ invasive procedure. If the patient is marked prior in the office the mark must be visible the day of surgery.

General Information:
1. Marking the site for verification is required by The Joint Commission, AAAHC, HFAP, and the Indianapolis Patient Safety Coalition. It is recommended by the American Academy of Orthopedic Surgeons, Sentinel Event Safety Alerts and is endorsed by more than 40 professional medical associations and organizations.
2. Marking the site:
   A. Write, "YES" on site.
   B. If the surgeon opts to indicate his/her initials at the site marking it will be in addition to the "YES".
3. At a minimum, mark all cases involving right/left distinction, including bilateral sites, multiple structures (fingers, toes, lesions), or multiple levels (spine).

   Exceptions:

   A. To Site Marking
      a. Teeth must be identified and documented on appropriate record using either a dental radiograph or a dental diagram.
      b. Premature infants, for whom the mark may cause a permanent tattoo.
      Interventional procedures where the catheter/instrument insertion site is not predetermined.
      c. Cases where it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, or obvious deformities).
      e. An alternative method for visual identification of correct side and site may be used.
      f. Placement of a temporary unique wrist band on the

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side of the procedure containing patient's name
and use of a second identifier for the intended procedure and site.

4. Cases where there is an immediate threat to life that would preclude site marking.
5. If the surgical site is a traumatic site or obvious, it does not have to be marked (single site suturing).
   B. To Time-Outs
      a. cases where there is an immediate threat to life that would preclude all but the following:
      b. An abbreviated time-out may be performed to verify patient identity, correct site and side.
6. The surgical site marking will take place in a pre-operative or pre- procedural area. No site marking will be done in the same room in which the surgery or procedure takes place. A "time-out" for final verification must still occur. (Refer to Time-Out prior to initiation of procedure).
   - Exemption:
     - Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a "time out" final verification still applies.

Equipment:
Single use marking pen (indelible ink)

Procedure:
Pre-operative unit/area

1. With the patient or representative involved, awake and aware if possible, the RN or procedural team member preparing the patient will verify the patient's identity using two (2) forms of identification; and verify the surgical procedure, location, any known allergies, a Consent for procedure has been signed and the H & P is verified as current, and updated if applicable. Any discrepancies found must be reported to the physician immediately.
2. With the patient or representative involved, awake and aware if possible, the operative site(s) is to be marked prior to the patient leaving the pre-operative area.
3. The site may only be marked by the physician performing the procedure and will be present at the time the procedure is performed.
4. The site is to be marked with the word "YES" to indicate appropriate site using a single use skin marker that is sufficiently permanent to remain visible after completion of skin prep and sterile draping. In addition, the physician may place their initials adjacent to the "YES" marking.
5. Sites are required to be marked with regard to laterality (right vs. left distinction), multiple structures (fingers, toes), and general spinal regions (cervical, thoracic, lumbar). Incision sites in the mid-line or though a natural orifice must be marked with laterality noted for paired structures.
6. The pre-op RN or procedural team member will verify the marked site with the physician's order, the Patient's Consent for Surgery and /or other Treatment, surgical/invasive procedural consent, history and physical, and schedule.
7. The RN or procedural team member will complete the documentation in the medical record on the Surgery/Invasive Procedure Site Verification Checklist. Exception: (See Documentation Guidelines, #1 Attachment A & #2). The checklist verifies the following items are available and accurately matched to the patient: correct diagnostic and radiology test results, any required blood products, implants, devices and/or special equipment if applicable; also relevant documentation regarding patient identity and procedure(s) to be performed.

Upon arrival in the pre-op/ procedural area

1. The surgical RN or procedural team member will verify the patient using two patient identifiers; the identified site with the physician's order, history and physical, surgery/invasive procedure consent prior to documenting on the Surgery/Invasive Procedure Verification Checklist.
2. The surgical RN or procedural Team member will verify if correct test and X-Rays are available, blood if needed and correct devices and equipment including implants The patient may then be transported to the surgery/invasive procedure area, after above is verified.

First "Time- Out"

1. Upon entry into the OR or procedural area the patient will be identified with two patient identifiers.
2. The procedure to be performed and any allergies verified.

3. There will be verbal acknowledgement from all members in the room.

Second "Time-Out" prior to initiation of procedure

1. Immediately prior to the initiation of the procedure, with the full surgical team present, the physician will initiate the time-out. If the physician does not take ownership of this process, the circulating RN or procedural team member will be charged with initiating this process.
2. The time-out involves verbal acknowledgement by every member of the team where any member is open and able to express concerns about procedure verification.
3. The initiator of the Time-out will verbally verify with the entire team:
   - Correct patient identity using two (2) patient identifiers.
   - Agreement on the procedure to be performed and accurate consent has been signed
   - Correct side and site have been visibly marked if applicable and correct patient position
   - Verify and document the name of the pre-operative antibiotic (if applicable) and the time it was started
   - Confirm the need to administer antibiotics or fluids for irrigation purposes if applicable
   - Confirm any safety precautions based on patient history or medication use if applicable
   - Verify all relevant images and results are properly labeled and appropriately displayed
   - Address the antibiotic if given; Yes it was given (or not, drug dosage, route, and time).
4. If any verification process fails to identify the correct site by any member of the team, all activities are halted until the discrepancy can be resolved and documented.
5. The entire time-out process is to be documented in the medical record.
6. When a single patient is undergoing multiple procedures that include a change in position/physician/procedure than a time-out is conducted just prior to each change. Each time-out is documented separately.

Closing "Time-out" and verification of counts

1. Prior to closure (if applicable) the physician, or circulating RN or procedural team member will initiate a time-out to verbally confirm:
   a. A review of surgical consent and procedures completed
   b. All specimens are identified, accounted for (visualized in the container) and accurately labeled
   c. All foreign bodies have been removed

Documentation Guidelines:

1. Document and complete the Surgery/Invasive Procedure Site Verification Checklist. See Attachment A.
2. Document any discrepancies and the action(s) taken in the appropriate form.
3. Complete the appropriate electronic health record or paper.

References:

Accreditation Association Ambulatory Health Care Accreditation Standards 2011, Chapter 10, Surgical and Related Services
The Joint Commission Universal Protocol and Guidelines for Preventing Wrong-Site, Wrong Procedure, Wrong Person Surgery, 12/03
AORN Position Statement on Patient Safety, Standards, Recommended Practices, and Guidelines, AORN 2011
AORN Position Statement on Correct Site Surgery, AORN Standards 2011
American Academy of Orthopedic Surgeons Advisory Statement of Wrong-Site Surgery. (AAOS On-Line Service, Wrong-Site Surgery)
Indiana Surgery Center, Indianapolis, Site Verification Policy, 1/10
Sentinel Event Alerts, 8/98; 12/01
2012 National Patient Safety Goals, the Joint Commission
Indianapolis Patient Safety Coalition Policy Universal Protocol 2008

Formulated by:
Verification Site Leadership Group, Chiefs of Anesthesia E/N/S, Executive Directors Indiana Surgery Centers, Medical Directors Indiana Surgery Centers, Vice President Surgical Services, Indianapolis Patient Safety Coalition, Chief Medical Officer VEI

Owner: Florence Miller, RN, CAPA
Regulatory Coordinator Surgical Services

Approved by: Peri-operative Nursing Subcommittee Group
Infection Prevention
Risk Management
Date: 4/12

Approved for Distribution: CNO Designee
Date: 4/12

Approved: _____
Chief Operations Officer
Date:

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
APPROVED FOR: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 11/10/10

NPP: C-47
Page 1 of 9
EFFECTIVE: 4/30/13

TITLE: COUNTS: SPONGES, SHARPS, NEEDLES, INSTRUMENTS

Performed by: RN, LPN, Student Nurse Extern, Student Surgical Tech, Certified Surgical Tech, Surgical Tech I, Equipment Prosthesis Coordinator, Private Scrub

Purpose: To outline a consistent and efficient method to account for all instruments, surgical sponges and sharps used during a specified surgical procedure.

Policy Statements:

A. The major goal of counting is to provide safe, appropriate care to the surgical patient; therefore, careful attention to the surgical count(s) is essential. Retention of a foreign object can cause life threatening injury to the patient and increase the liability of the surgeon, OR staff and the facility.
B. Accountability for surgical counts is the responsibility of the entire team, including the surgeon, anesthesiologist and circulating and scrub staff.
C. Circulating and scrub staff are required to complete the counts audibly for the entire team to hear. This communication is essential to patient safety.
D. Any item that is not counted will not be placed in the wound.
E. The type of case will determine if counts are needed, and what is to be counted.
F. Counts on sponges, surgical sharps/needles, and other small items should be performed:
    1. Before the procedure to establish a baseline.
    2. Whenever performing a prepfor a cavity case, ie, vaginal, rectal or wound staff are required to use an RF tagged raytex sponge or a disposable sponge stick. RF tagged sponges are required to be counted before and after the prep and also included in the overall sponge count process for the procedure.
    3. Before the closure of a cavity within a cavity.
    4. Before wound closure begins.
    5. At skin closure or at the end of the procedure.
G. Instrument counts should be performed (when applicable):
    1. Before the procedure to establish a baseline.
    2. Before the closure of a body cavity. Often this count accompanies the first sponge and sharp(s) count.
H. For those sites that utilize RF Technology, the RF Detection System does not replace the need for a manual, verbal, and/or visual sponge count. See separate departmental policy for the RF Detection System if sponges are being utilized at your site, for timing of scan(s), frequency of use, and types of cases in which the technology will be implemented.
I. If the staff members who did the original count are leaving this procedure and not returning,, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible).
J. The circulator records the count on a count worksheet. This worksheet will be used to keep accurate records during the operation. The worksheet will be discarded at the end of the case.
K. The surgeon and anesthesiologist should be informed of each count.
L. The circulator is responsible for accurately documenting the counts on the operative record.
M. In the interest of patient safety, no patient will leave the OR until all indicated counts have been completed and confirmed with the surgeon.
N. A Confidential Peer Review report will be initiated for any count discrepancy.

General Information: None.

Equipment: None.

Procedure:

A. Sponges:
   1. Surgical sponges to be counted included:
      a. Laparotomy sponges (laps) 5/unit
      b. Raytex 10/unit
      c. Kitners 5/unit
      d. Tonsils 5/unit
      e. Cottonoids 10/unit
      f. Section sponges (tails) 5/unit
      g. Any radiopaque sponge
      h. Blue towels if they are placed in the wound – 1 per unit.
   2. Count all surgical sponges prior to the start of the procedure. **Exception:** Surgical sponges do not have to be counted on arthroscopic procedures, cataract extraction, retinal detachments, or vitrectomy procedures. The circulator records the count on a count worksheet. Following this count, do not remove any sponges, trash or linens from the Operating Room.
   3. Sponges may be counted as total number of sponges. When counting in units, you must validate the total number of sponges.
   4. The scrub discards raytex, laparotomy and section sponges from the operative field either onto a designated area on the floor (drop cloth) or into a plastic lined kick bucket.
   5. Kitners, cottonoids, or tonsil sponges should remain on the field until a complete unit (as described above) is assembled. Once two members of eth OR team have counted those sponges, they may be passed off the sterile field and bagged.
   6. The circulator opens and lays the discarded sponges in units in an orderly fashion, on a designated area to ensure that no sponges are hidden within one another, and to facilitate estimation of blood loss on the sponges.
   7. Each sponge should be separated from the other sponges so the radiopaque marker is visible on each sponge.
   8. An RN and another individual count aloud and in unison with both concurrently viewing each sponge as it is counted.
   9. After the initial count, any additional sponges should be counted and recorded in the same manner.
   10. If a radiopaque sponge is cut or trimmed, account for it in its entirety. This includes strings off laparotomy sponges.
   11. Sponges may be bagged in units, per department protocol, with the consent of the anesthesiologist and/or surgeon. Counter bags may used when appropriate.
   12. If the "unit" of sponges does not contain the exact number of sponges as specified above, do not use that unit of sponges. Scrub passes the unit to the circulator who secures them in a plastic bag and removes them from the Operating Room. Do not record them on the count worksheet.
   13. Complete closing counts:
      a. At the start of closure of any deep, or large incision or body cavity
      b. At the completion of closure of any body cavity
      c. At the start of the closure of the outermost layer (eg skin)
   14. **Exceptions:** If a large organ is opened (eg uterus or bladder), perform an additional closing count as the surgeon begins to close the organ.
      Perform closing counts in this order:
      a. Operative field
      b. Mayo stand
      c. Back table

d. Sponges discarded off of the sterile field

15. For those sites that have implemented RF technology, please refer to your departmental protocol on the timing and frequency of scanning the patient.
16. If the staff member who did the original count are leaving this procedure and not returning, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible). This extra count will be completed before both of the original staff members, the circulator and scrub, leave the case.
17. Inform the surgeon and the anesthesiologist of the results of each sponge count.
18. The circulator records the results, quantity of counts, and the name and title of persons performing the counts on the operative record.
19. If a radiopaque surgical sponge is used as packing, the circulator records the location and type of sponge on the operative record.
20. If the count is incorrect
    a. Notify the surgeon, anesthesiologist and/or charge nurse.
    b. Recount the sponges
    c. Immediately perform a search of the field and/or room (eg trash, hampers, floor of the operating room, etc.)
    d. If available, utilize RF technology to scan the patient and/or trash and linens (per departmental protocol).
    e. Surgeon will search the wound and/or cavity as appropriate.
    f. Call for an X-ray of patient (while patient is still in the OR and under anesthesia) under the guidance of the surgeon/anesthesiologist.
    g. Circulator enters "incorrect" on the operative record and documents actions on a multidisciplinary note.
    h. Complete a Confidential Peer Review report.

B. Surgical Sharps/Needles/and Other Small Items:
1. Surgical sharps to be counted included (but not limited to):
    a. Suture needles
    b. Scalpel blades
    c. Hypodermic needles
    d. Electrosurgical tips
    e. Safety pins
    f. Items such as bovie scratchers, vessel loops bulldog clamps, etc. are counted at the discretion of the OR personnel
2. The procedure for counting surgical sharps/needles and/or other small items follow the same count procedure as sponges. Sponge and sharp counts should occur at the same time. See policy statement.
3. Count all surgical sharps prior to the start of the procedure. **Exception:** Hypodermic needles do not have to be counted on cataract extraction, retinal detachments, or vitrectomy procedures. Count suture needles according to the number marked on the outer package. An RN and another individual count aloud and in unison with both concurrently viewing each sharp as it is counted. The circulator records the count on a count worksheet. Following this count, do not remove any sharps, trash or linens from the Operating Room.
4. The scrub validates the actual number of suture needles when the package is opened.
5. Count and record any sharps added after the initial count in the same manner.
6. If a surgical sharp is broken, account for it in its entirety.
7. Complete closing counts:
    a. At the start of closure of any deep, or large incision or body cavity.
    b. At the completion of closure of any body cavity.

c. At the start of the closure of the outermost layer (e.g., skin)

Exceptions: If a large organ is opened (eg uterus or bladder), perform an additional closing count as the surgeon begins to close the organ.

8. Perform closing counts in this order:
   a. Operative field
   b. Mayo stand
   c. Back table
   d. Sharps discarded off the sterile field
9. If the staff members who did the original count are leaving this procedure and not returning, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible). This extra count will be completed before both of the original staff members, the circulator and scrub, leave the case.
10. Inform the surgeon and anesthesiologist of the results of each sharp count.
11. The circulator records the results, quantity of counts, and the name and title of persons performing the counts on the operative record.
12. If the count is incorrect:
    a. Notify the surgeon, anesthesiologist and/or charge nurse.
    b. Recount the sharps
    c. Immediately perform a search of the field and/or room (eg trash, hampers, floor of the operating room, etc.)
    d. If the sharp is not located, the surgeon may search the wound and/or cavity as appropriate.
    e. An X-ray of patient may be performed (while patient is still in the OR and under anesthesia) under the guidance of the surgeon/anesthesiologist.
    f. Circulator enters "incorrect" on the operative record and documents actions on a multidisciplinary note.
    g. Complete a Confidential Peer Review Report.

C. Instruments:
1. Count instruments on all procedures entering the peritoneal, retroperitoneal, thoracic cavities and open heart procedures on all patients weighing greater than 25 pounds. **Exception:** (a) An instrument count does not have to be done on laparoscopic procedures unless an open laparotomy is planned or another cavity is entered.
2. Instruments will be counted when sets are assembled for sterilization. This assembly count provides a basic reference for the instrument set and is not considered the initial instrument count.
3. Initial counts in the OR will be performed to establish a baseline for subsequent counts.
4. An RN and another individual count aloud and in unison with both concurrently viewing each instrument as it is counted. The circulator records the count on a count worksheet.
5. Count and record any instrumentation added to the overall count.
6. Account for any instruments disassembled or broken in their entirety.
7. If the staff members who did the original count are leaving this procedure and not returning, then a new count(s) should be initiated with the new team members (although direct visualization of all items may not be possible). This extra count will be completed before both of the original staff members, the circulator and scrub, leave the case.
8. If there are multiple procedures on a patient that require more than one set of instruments, count all opened instruments/sets (if one of the procedures falls into the guidelines for instrument counts listed above).
9. Complete one closing instrument count with first sponge and sharp(s) counts.
10. Additional counts may be performed at the discretion of OR personnel when they deem necessary, or if significant risk for leaving instruments within the operative site exists. Document any counted

instruments removed from the Operating Room during a surgical procedure on the count worksheet.

11. Inform the surgeon and anesthesiologist of the accuracy of each instrument count.
12. The circulator records the results, quantity of counts, and the name and title of persons performing he counts on the operative record.
13. An X-ray done at the closing of any procedure entering the peritoneal, retroperitoneal,, thoracic, or pericardial cavities eliminates the need to perform an instrument count, but counting is preferable if at all practical. The X-ray will include entire body cavity involved, and will be performed just after all retractors are removed.
14. In an emergent situation, counts are not considered a priority, although an X-ray will be required at the end of the case. If time permits, counting is preferable to ensure patient safety.
15. If the count is incorrect:
    a. Notify the surgeon, anesthesiologist and/or charge nurse.
    b. Recount the instruments. It can be beneficial to have another scrub count for you.
    c. Immediately perform a search of the field and/or room (eg trash, hampers, floor of the operating room, autoclave, etc.)
    d. Surgeon will search the wound and/or cavity as appropriate.
    e. Call for an X-ray of patient (while patient is still in the OR and under anesthesia) under the guidance of the surgeon/anesthesiologist.
    f. Circulator enters "incorrect" on the operative record and documents actions on a multidisciplinary note.
    g. Complete a Confidential Peer Review report.

Documentation Guidelines: The number and results of counts are recorded on the Operative Record. Actions taken will be documented on the Multidisciplinary Notes. Discrepancies will be initiated on a Confidential Peer Review Report.

References: AORN Standards and Recommended practices, 2010
National Institute for Occupational Safety and Health, Publication no. 97-111, January, 1998

Approved by:	Perioperative NPP Subcommittee	
	Risk Management	Date: 3/13/13
	Infection Control	Date: 3/13/13
	CHVH	Date: 3/13/13
Approved:	NPP Steering Committee	Date: 3/13/13

TITLE: RF (Radio Frequency) SURGICAL DETECTION SYSTEM

Performed by: RN, LPN, Certified Surgical Tech (CST), Student Nurse Extern, Surgical Tech student, Private Scrub who are competency verified.

Purpose: To verify a correct sponge count as well as to provide additional safety against accidental sponge retention within a surgical wound.

Policy Statements:

1. Use of the RF Surgical Detection System does not replace the need for a manual, verbal, visual sponge count (NPP: C-47).
2. The RF Detection System will be used for the following procedures:
   a.) All open cavity (thoracic, abdominal, pelvic)
   b.) Hand-assisted thorocoscopy, colectomy, thorocotomy, nephrectomy, etc.
   c.) All emergent cases in which an initial sponge count was unable to be attained.
   d.) All incorrect sponge counts
3. The RF Detection System should NOT be used on patients with Automatic Internal Cardiac Defibrillator (AICD); VAD; permanent pacemaker, or any procedures that are scheduled with intraoperative magnet usage.
4. The RF Detection system will be used prior to final wound closure as well as after skin closure. A minimum of (2) scans must be done.
5. RF tagged surgical sponges (raytecs and lap sponges) will be the only sponge type stocked and used within the department.

Equipment:

1. Radio Frequency (RF) tagged raytec sponges and lap sponges.
2. Reusable hand-held Blair-Port Wand RF Surgical detection wand
3. RF Surgical Detection Console

Procedure:

A.) Calibration of Console

1. At the start of closure of the incision or body cavity circulating nurse and scrub nurse will perform a manual/visual sponge count.
2. The sterile surgical wand will be opened to the sterile field.
3. Circulator turns the RF Console to the "ON" position.
4. Circulator will plug the RF wand into the RF Console.
5. Scrub nurse will hold the wand above the patient in order to calibrate the wand.
6. The green light will illuminate indicating the system is ready for use.
7. The scrub nurse will test wand with an RF detect sponge by looking and listening for alarm.

B.) Appropriate adjustments to the settings of patient medical devices must be made before beginning the scanning procedure. **Temporary pacers must be in Non-Demand Mode. ***

C.) Scanning Procedure must include both a vertical and horizontal scan and each pass of the wand should take approximately 3 seconds to complete.

1. Vertical Scan (See Attachment A)
   a.) Position wand parallel to the body as close as possible.
   b.) With wand remaining parallel to the body, move the wand distally from head to toe (Pass #1).
   c.) When at the toe, continue to move wand parallel to body up to the left shoulder (Pass #2)
   d.) With wand parallel to the body, move wand down the left side of body (Pass #3).
   e.) Keeping wand parallel to body continue from the left foot in a diagonal motion across the body to the right shoulder (Pass #4).
   f.) Keeping wand parallel to patient's body, continue from the right shoulder down the right side of patient's body (Pass # 5).
   g.) Keeping wand parallel to the patient's body, the final pass will return the wand from the lower right side of body up to the head (Pass #6).

2. Horizontal Scan: (See Attachment A)
   a.) Position wand parallel to body on lateral side of torso beginning at the shoulder.
   b.) Keeping wand parallel to body, move wand in an arc motion to opposite side of torso. (Pass #1 right shoulder to left shoulder).
   c.) Keeping wand parallel to body, move wand in an arc motion to opposite side of torso (Pass #2 left shoulder to right abdomen).
   d.) Keeping wand parallel to body, move wand in an arc motion to the opposite side of torso (Pass #3 Right abdomen to left abdomen).
   e.) Keeping wand parallel to body, move wand in an arc motion to the opposite side of torso (Pass #4 Left abdomen to right iliac region).
   f.) Keeping wand parallel to body, move wand in an arc motion to the opposite side of torso (Pass #5 Right ileac region to left ileac region).

C.) If the presence of an item is identified by the RF Surgical Detection System, begin exploring the incision or cavity and repeat scanning procedure until all sponges are accounted for.

D.) The patient and all linen and waste containers will be scanned according to the RF scanning procedure to locate missing surgical sponges in order to resolve the final count

E.) If unable to locate missing sponge with RF wand, follow the procedure for incorrect counts in nursing policy NPP:C-47.

Documentation Guidelines

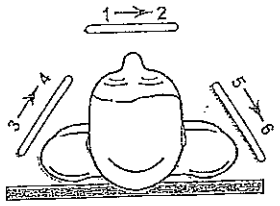
The number and results of counts performed by the Perioperative Team are recorded on the Operative Record. Documentation of usage of the RF Surgical Detection System must be written in the Multidisciplinary Notes. Discrepancies will be initiated on a Confidential Peer Review Report.

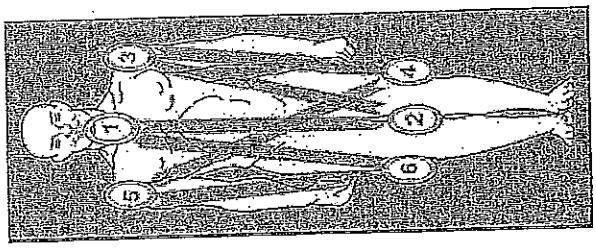
References

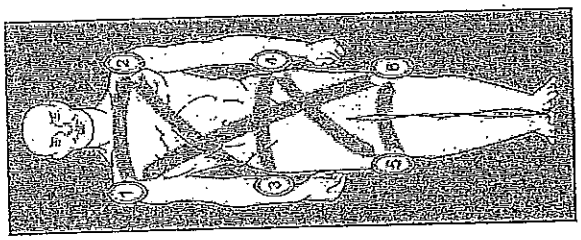
1.) Evidence for Practice. (2007). Radio frequency identification and surgical Detection. *Association of PeriOperative Registered Nurses Journal*, 85 (3), 638-639.

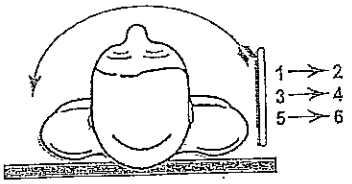
2.) Jackson, S. & Brady, S. (2008). Counting difficulties: Retained instruments, Sponges, and needles. *Association of PeriOperative Registered Nurses Journal*, 87 (2). 315-321.

3.) RF Surgical™ Detection System Model 100A Rev 5 Owners Manual; RF Surgical Systems Inc.









Pictures provided by FR Surgical™ Systems Inc.

CHS Sponge Counting Protocol

1) Sponge counts should be taken:
   a. - Before the procedure to establish a baseline (initial count)
   b. - Before closure of a cavity within a cavity
   c. - Before wound closure begins
   d. - At skin closure or end of procedure

2) Initial count:
   a. – Sponges should be separated, counted audibly, and concurrently viewed during the count procedure by the scrub nurse and the circulating nurse.
   b. – The circulating nurse should document the initial sponge count at this time.

3) During the procedure:
   a. – All contaminated sponges shall be discarded from the surgical field to a floor drape.
   b. – The circulating nurse shall separate the contaminated sponges on the floor drape and maintain them in an orderly fashion. Sponge counter bags for sponge separation are NOT permitted.

4) Before closure of a cavity:
   a. – Prior to closure of a cavity, the first sponge count shall be performed. The count should begin at the surgical site and the immediate surrounding area, proceed to the mayo stand and back table, and finally to sponges that have been discarded to the floor drape.
   b. – Sponges should be counted audibly and concurrently viewed during the count procedure by the scrub nurse and the circulating nurse.
   c. – If discrepancy the circulating nurse shall inform the surgeon, otherwise the circulating nurse shall document first sponge count correct at this time.

5) Before wound closure begins:
   a. – Prior to wound closure, the second sponge count shall be performed. The count should begin at the surgical site and the immediate surrounding area, proceed to the mayo stand and back table, and finally to sponges that have been discarded to the floor drape.
   b. – Sponges should be counted audibly and concurrently viewed during the count by the scrub nurse and the circulating nurse.
   c. – If discrepancy the circulating nurse shall inform the surgeon, otherwise the circulating nurse shall document second sponge count correct at this time.

6) At skin closure or end of procedure:
   a. – At skin closure or end of procedure, a third/final sponge count shall be performed. The count should begin at the surgical site and the immediate surrounding area, proceed to the mayo stand and back table, and finally to sponges that have been discarded to the floor drape.
   b. – Sponges should be counted audibly and concurrently viewed during the count by the scrub nurse and the circulating nurse.
   c. – If discrepancy the circulating nurse shall inform the surgeon, otherwise the circulating nurse shall document third/final sponge count correct at this time.
   d. – Surgeon shall be informed by circulating nurse that all sponge counts are correct.

7) Permission for sponge disposal:
   a. – Anesthesia shall view sponges for estimated blood loss and give permission for disposal.

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 12

Critical Care Physician Coverage

12. "**Critical Care Physician Coverage.** Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients. There must be prompt availability of Critical Care physician coverage 24 hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage 24 hours per day.

Narrative Response and Discussion

The requirements of section 12 are met with a letter of commitment from Community Hospital South's Medical Director of Critical Care affirming 24 hour availability of critical care physician coverage.

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June 24, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the ACS verification Process" for Level III Trauma Center designation.

The purpose of this correspondence is to inform the committee that I serve as the Director of Critical Care. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center requirements. Our team will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

As the Director of Critical Care I understand that my role is to ensure that there is prompt availability of Critical Care Physician coverage twenty-four hours per day. The critical care physicians at Community Hospital South work closely with all of the physicians involved in the care of the trauma patient.

Respectfully,

Sultan Niazi M.D.
Director of Critical Care

Edward Diekhoff M.D., F.A.C.S
Trauma Medical Director

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April 2014

Pulmonary South Call Schedule

Always call the answering service for Dr. Abbasi and Dr. Niazi:

Dr. Kawak's answering service:

Call starts at 5:00 PM on Weekdays and ends at 7:00 am the next day.

Weekend call starts at 12:00 noon Friday and ends at 7:00 AM Monday.

Sun	Mon	Tue	Wed	Thu	Fri	Sat
		1 Niazi Floor—Niazi ICU—Niazi	2 Abbasi Floor—Niazi ICU—Abbasi	3 Niazi Floor—Niazi ICU—Abbasi	4 Kawak Floor—Niazi ICU—Abbasi	5 Kawak
6 Kawak	7 Abbasi Floor & ICU—Abbasi	8 Abbasi Floor & ICU—Abbasi	9 Abbasi Floor & ICU—Abbasi	10 Kawak Floor & ICU—Abbasi	11 Kawak Floor —Abbasi ICU—Niazi	12 Kawak
13 Kawak	14 Kawak Floor—Niazi ICU—Abbasi	15 Kawak Floor—Niazi ICU—Abbasi	16 Kawak Floor—Niazi ICU—Abbasi	17 Kawak Floor—Niazi ICU—Abbasi	18 Abbasi Floor—Niazi ICU—Abbasi	19 Abbasi
20 Abbasi	21 Niazi Floor —Abbasi ICU—Niazi	22 Niazi Floor —Abbasi ICU—Niazi	23 Niazi Floor —Abbasi ICU—Niazi	24 Niazi Floor —Abbasi ICU—Niazi	25 Niazi Floor —Abbasi ICU—Niazi	26 Niazi
27 Niazi	28 Abbasi Floor—Niazi ICU—Abbasi	29 Abbasi Floor—Niazi ICU—Abbasi	30 Abbasi Floor—Niazi ICU—Abbasi	May 1 Niazi Floor—Niazi ICU—Abbasi		

VACATIONS:
Niazi: April 7-10
Abbasi: April 1

MAY 2014

Pulmonary South Call Schedule

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1 NIAZI ICU-Abbasi Floor-Niazi	2 ABBASI ICU-Abbasi Floor-Niazi	3 ABBASI
4 ABBASI	5 NIAZI ICU-Niazi Floor—Abbasi	6 ABBASI ICU-Niazi Floor—Abbasi	7 ABBASI ICU-Niazi Floor—Abbasi	8 ABBASI ICU-Niazi Floor—Abbasi	9 NIAZI ICU-Niazi Floor—Abbasi	10 NIAZI
11 NIAZI	12 KAWAK ICU-Abbasi Floor-Niazi	13 KAWAK ICU-Abbasi Floor-Niazi	14 KAWAK ICU-Abbasi Floor-Niazi	15 NIAZI ICU-Abbasi Floor-Niazi	16 KAWAK ICU-Abbasi Floor-Niazi	17 KAWAK
18 KAWAK	19 NIAZI ICU-Niazi Floor—Abbasi	20 NIAZI ICU-Niazi Floor—Abbasi	21 NIAZI ICU-Niazi Floor—Abbasi	22 KAWAK ICU-Niazi Floor—Abbasi	23 ABBASI ICU-Niazi Floor—Abbasi	24 ABBASI
25 ABBASI	26 ABBASI ICU-Abbasi Floor-Niazi	27 KAWAK ICU-Abbasi Floor-Niazi	28 ABBASI ICU-Abbasi Floor-Niazi	29 ABBASI ICU-Abbasi Floor-Niazi	30 NIAZI ICU-Abbasi Floor-Niazi	31 NIAZI

Always call Answering Service for Dr. Abbasi and Dr. Niazi

Dr. Kawak's Answering Service:

Call Starts at 5:00PM on weekdays and ends at 7:00AM the Next Day.

Weekend Call starts at 12:00 noon on Friday and ends at 7:00AM on Monday.

JUNE 2014

Pulmonary South Call Schedule

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 NIAZI	2 KAWAK ICU-Niazi Floor-Abbasi	3 KAWAK ICU-Abbasi Floor-Abbasi	4 KAWAK ICU-Abbasi Floor-Abbasi	5 KAWAK ICU-Abbasi Floor-Abbasi	6 KAWAK ICU-Abbasi Floor-Abbasi	7 KAWAK
8 KAWAK	9 KAWAK ICU-Abbasi Floor-Abbasi	10 KAWAK ICU-Abbasi Floor-Abbasi	11 KAWAK ICU-Abbasi Floor-Abbasi	12 KAWAK ICU-Abbasi Floor-Abbasi	13 ABBASI ICU-Abbasi Floor-Abbasi	14 ABBASI
15 ABBASI	16 ABBASI ICU-Abbasi Floor-Abbasi	17 ABBASI ICU-Abbasi Floor-Abbasi	18 ABBASI ICU-Abbasi Floor-Abbasi	19 ABBASI ICU-Niazi Floor-Abbasi	20 NIAZI ICU-Niazi Floor-Abbasi	21 NIAZI
22 NIAZI	23 NIAZI ICU—Abbasi Floor-Niazi	24 NIAZI ICU—Abbasi Floor-Niazi	25 NIAZI ICU—Abbasi Floor-Niazi	26 NIAZI ICU—Abbasi Floor-Niazi	27 ABBASI ICU—Abbasi Floor-Niazi	28 ABBASI
29 ABBASI	30 ABBASI ICU-Niazi Floor-Abbasi					

Always call Answering Service for Dr. Abbasi and Dr. Niazi

Dr. Kawak's Answering Service:

Call Starts at 5:00PM on weekdays and ends at 7:00AM the Next Day.

Weekend Call starts at 12:00 noon on Friday and ends at 7:00AM on Monday

Vacations:

Niazi: June 3-18

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 13

CT Scan and Conventional Radiology

13. "**CT Scan and Conventional Radiography.** There must be 24 hour availability of CT Scan and conventional radiography capabilities. There must also be a written letter of commitment form the hospital's Chief of Radiology."

Narrative Response and Discussion

The requirements of section 13 are met with signed letters of commitment from Community Hospital South's Radiology Section Chairman and the Director of Medical Imaging affirming compliance with American College of Surgeons requirements for CT scan and conventional radiography. The x-ray department is included in the tiered activation system for our facilities Code Traumas.

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1402 E. County Line Road
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June 03, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the process ACS verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as the Chairman for the Radiology Department at Community Hospital South. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure prompt medical imaging interpretation including CT scan and conventional radiography is available at Community Hospital South twenty-four hours per day.

Respectfully,

Paul W. Sheets MD

Paul Sheets M.D.
Department of Radiology
Chairman

Edward Diekhoff MD FACS

Edward Diekhoff, M. D, F.A.C.S.
Trauma Medical Director

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June 25, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the process ACS verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve as Director of Medical Imaging for Community Hospital South. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure medical imaging including CT scan and conventional radiography is available at Community Hospital South twenty-four hours per day. Our X-ray department is included in our tiered activation system and must respond to all Code Traumas.

Respectfully,

Shawna A. Thomas

Shawna A. Thomas, RN, BSN
Director Emergency Department
Director Medical Imaging

Edward Diekhoff FACS

Edward Diekhoff, M. D, F.A.C.S
Trauma Medical Director

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COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action
6/01/14	Reviewed		

Effective	6/01/14
Major Change	____
Minor Change	____
New Policy	6/01/14
Cancels	____

TITLE: **ED PATIENT CT SCANNING**

STATEMENT OF PURPOSE: To clarify scope of services for CT equipment, CT Technologists, and Radiologists.

TEXT: The CT scanner, located in the Medical Imaging Department, is available 24/7 and staffed 24/7 with a CT technologist.

1. All scans at Community Hospital will be performed under the general supervision of a staff radiologist.
2. Scans will be transmitted via the telerad system (PACs) to the Radiologist.
3. Intravenous administration of contrast will be done only under the directive of a staff physician or Radiologist and will be injected by a Radiological Technologist. There will always be a staff physician or Radiologist available to assume responsibility for the patient that is receiving intravenous contrast media.
4. Oxygen is located in the wall in the CT scanner rooms.
5. If a patient has a contrast reaction, the CT Technologist is to immediately notify the Radiologist or ER physician. If the reaction is life threatening, the technologist or other available staff will institute "Code Blue" by calling 66.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

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COMMUNITY HEALTH NETWORK
MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE
APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action
6/01/14	Reviewed		

Effective	6/01/14
Major Change	_____
Minor Change	_____
New Policy	6/01/14
Cancels	_____

TITLE: **QUALIFICATIONS AND RESPONSIBILITIES OF THE RADIOLOGISTS**

STATEMENT OF PURPOSE: To set forth qualifications and duties of the Radiologists.

Radiology exams must be obtained under the supervision of, and interpreted by, a licensed physician with the following qualifications.

1. The physician shall have documented a minimum of six (6) months of formal dedicated training in the interpretation and form reporting of radiology exams in an ACGME-approved residency program, including radiographic training on all body areas of which he/she intends to interpret radiographic studies.
2. The physician should have documented training and understanding of the physics of diagnostic radiography and of the equipment needed to safely produce images. This should include plain-film radiography, film-screen combinations, conventional image processing and where applicable, digital image processing.
3. The physician must be familiar with the principles of radiation protection, the hazards of radiation exposure to both patients and radiologic personnel, and radiation monitoring equipment.
4. The physician shall have documented training and understanding of all imaging modalities (plain radiography, fluoroscopy, computed tomography, ultrasound, MRI, nuclear medicine, etc.) and their value in the evaluation of the patient's clinical symptoms.
5. Certification in Radiology and/or Diagnostic Radiology by the American Board of Radiology, and/or American Osteopathic Board of Radiology or as credentialed by the medical staff office.
6. All Physicians practicing diagnostic Radiology are members of the medical staff. Their credentials, located in the Medial Staff office, reflect their experience and current competency requirements for all aspects of Radiology services in which they are engaged.

All physicians performing radiography exams who have met the above criteria should also demonstrate evidence of continued competence and appropriate care to the performance and interpretation of radiography exams.

1. A minimum of 300 exams per year is recommended in order to maintain a high level of expertise. If the volume of an imaging modality is too low to maintain this standard, continued qualification is maintained if acceptable the technical success, accuracy of interpretation and appropriateness evaluation is monitored.
2. The physician's continuing medical education should be in accordance with the ACR Standard for Continuing Medical Education (CME).

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action
6/1/14	Reviewed		

Effective	6/01/14
Major Change	_____
Minor Change	_____
New Policy	6/01/14
Cancels	_____

TITLE: TELERADIOLOGY

STATEMENT OF PURPOSE: Scope of service to provide transmission and viewing capability of medical imaging procedures to an off-site location.

Teleradiology is the electronic transmission of radiologic images from one location to another for the purposes of interpretation and/or consultation. The use of teleradiology does not reduce the responsibilities of the Radiologists for the management and supervision of radiologic procedures.

The goals of teleradiology are:
1. To provide consultative and interpretative radiological services.
2. To facilitate radiological interpretations in any situation.
3. To provide direct supervision during off-site situations.

In the event that the teleradiology system is inoperable the following should be done:
1. The PACs administrator should be notified.
2. If necessary, service calls to the appropriate vendors will be made by the PACs administrator on-call.
3. The Radiologist will provide on-site interpretation or consultation services, as needed, following notification of the problem with the teleradiography system.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action
6.1.14	Reviewed		

Effective	6.1.14
Major Change	____
Minor Change	____
New Policy	6.1.14
Cancels	____

TITLE: **Emergency Department Radiologic Examinations (X-ray)**

STATEMENT OF PURPOSE: To set forth guidelines for the safe, efficient service for the Emergency Department. As performed by Radiologic Technologist, and Radiologist.

1. Radiology (X-ray) is available 24/7 on-site with additional X-ray staff available on-call as needed.
2. Appointments for Emergency Department patients are not necessary. When applicable, ED patients will be radiographed in the ED room with portable X-ray. If there is not a technologist in the X-ray department when an ED patient is ready, the X-ray technologist will be notified via vocera or mobile phone by the ED department.
3. Emergency department patients will be done in the order the exam are placed "ready" in EPIC, unless otherwise directed by the ED staff.
4. Whenever possible, ED patients will take precedence over inpatients and out patients.
5. If it is necessary for the patient to be transferred to another hospital CD images will be provided upon the EDs request.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action
6/01/14	Reviewed		

Effective	6/01/14
Major Change	____
Minor Change	____
New Policy	6/01/14
Cancels	____

TITLE: **RADIOLOGIST COVERAGE**

STATEMENT OF PURPOSE: Scope of service for staff Radiologists and to provide adequate medical coverage to meet customer needs.

Irvington Radiologists provide coverage for the Radiology Departments of Community Health Network.

1. Radiologists are present in the hospital from 8:00 AM to 4:30 PM and from 4:30 PM to 8:00 AM a Radiologist is present on-site at one location and is available via phone 24/7.
2. Radiologists are always available for consultation with ordering physicians 24/7.
3. All Physicians practicing diagnostic Radiology are members of the medical staff. Their credentials, located in the Medial Staff office, reflect their experience and current competency requirements for all aspects of Radiology services in which they are engaged.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action
8/05	Revised	8/95	Reviewed
11/07	Revised	12/97	Revised
02/10	Revised	2/99	Reviewed
03/12	Revised	2/01	Revised
08/12	Revised	1/03	Revised
03/13	Revised		
06/14	Reviewed		

Effective	2/93
Major Change	08/05, 11/07
Minor Change	08/12, 03/13
New Policy	_____
Cancels	_____

TITLE: **REPORTING EXAM RESULTS**

STATEMENT OF PURPOSE: To describe the mechanisms/processes for communicating and distributing exam or procedural results that are in preliminary or final status.

1. EMERGENCY DEPARTMENT REPORTS

After exam completion, the digital image is electronically sent to PACS where it is immediately available for viewing by the radiologist and other physicians with PACS access (includes ED physicians, staff physicians and cardiovascular surgeons). These images, which are always treated as "STAT," are interpreted promptly by Radiologists (24-7) via voice recognition. (At Community South, ED physicians initiate wet-reads during the hours of 1 a.m. – 6 a.m.).

The preliminary/final reports become available in PACS and are viewed by the network Emergency Department physicians.

Exception – Community Hospital South during night shift hours: At CHS, "Night Hawks", an independent radiology group, is contacted to view advanced modality images, sent from CHS Radiology. A requisition specific to Night Hawks is faxed to them to obtain a preliminary reading. After interpretation, the Night Hawk radiologist sends a faxed report back to the Community South technologist. This is matched up with the CHI Medical Imaging Requisition and given final interpretation the next day by Radiology Associates of Indiana (RAI). Diagnostic X-rays will receive a preliminary interpretation by the Emergency Department physician, and a final interpretation is made the following morning by RAI radiologists.

2. ALL STATS

All "Call Reports, Hold & Calls, and "fax to" actions are documented in **Exam Memo** (in PACS) by the Imaging Support staff.

3. OUTPATIENTS

After exam completion, all routine outpatient exams/procedures are generally dictated within 24–48 hours with few exceptions (awaiting more images, etc.). However, any completed exam, not read by the following business day, is tracked in the Imaging Record Room as a quality indicator. Resolution to any unread exam is promptly brought to the Radiologist's attention.

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

☑CHE ☑CHN ☑CHS ☑CHVH

4. INPATIENTS

All STAT, Call Doctor and/or Hold & Call requests will be interpreted within the approved guidelines. Any off-site comparisons will follow as an addendum. STAT and "call report" exams are called to the nursing unit by the imaging record room staff or, in some cases, by the technologists. This communication is documented in PACS "Exam Memo." For critical results on a routine inpatient exam – the ordering physician and/or patient nurse (RN) will be called immediately by the radiologist. All inpatient exams are monitored to ensure that all exams receive, at minimum, a preliminary result within 24 hours.

5. EMERGENCY BACK-UP IN THE EVENT OF NETWORK PACS FAILURE

Should there be complete failure of the digital image management system (PACS), the radiologist on-site will begin to interpret from hard copy film or modality workstation. **If no radiologist is on-site, the "on-call radiologist" will be notified to come in.*

6. DISCREPANCIES

If at any time a discrepancy is noted from the original preliminary or final report, a corrected interpretation will be dictated, with prompt communication to the ordering physician.

7. CRITICAL RESULT REPORTING

Critical Results are defined as potential life-threatening or serious findings that need reported to the ordering physician immediately. Community Health Network, along with the radiologists, has designated specific criteria/results that get monitored and audited. This doesn't exclude the fact that "other" critical results occur and are dealt with accordingly. Regardless of type of patient *(Inpatient, Outpatient, ED patient, Imaging Centers, Medchecks, Community Heart and Vascular Hospital))*, critical results will be called immediately (not to exceed 30 minutes of the radiologist's interpretation time. They are to be called to the ordering physician or licensed caregiver (MD, DO, P.A., N.P, RN). **The call is to be made by the interpreting radiologist**. If the receiver is an R.N., they will be asked to "read back and verify" the results. The name of the person receiving the result, their title and the time of the call is required to be dictated, by the radiologist, within the body of the report.

The radiologist, in conjunction with input from other medical sections, will maintain the list of critical result criteria and make changes as necessary or with recommendations from other medical staff departments. The imaging department will track compliance with the defined 30 minutes turn-around- time. This data will be reviewed daily and analyzed. The data collected will be put in a monthly audit report. This report is shared with Hospital Quality Assurance and the Radiologist's Section Chairman (CHE-CHN-CHVH and CHS).

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COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

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8. REPORT DISTRIBUTION

Reports are digitally stored in Phillips PACS (Archive) for permanent retrieval. Health Information Management (Medical Records) receives an electronic copy for the patient's electronic medical record. A copy of the report also is delivered to the ordering physician via electronic distribution, mail, courier, or auto fax.

See * Attachment "A" – Critical Results Reference Revised – 01/2012

Formulated by: Deb Hayden & /Kathy Steffen

ATTACHMENT "A"
CRITICAL RESULTS REFERENCE

- New Pulmonary Embolus
- Ruptured Aortic Aneurysm
- New Aortic Dissection
- New Intracranial Hemorrhage
- Potentially Life-Threatening Hemorrhage - any location
- Acute appendicitis
- New Unexplained/Unexpected Pneumothorax – MD decision to call if critical!

  Ectopic Pregnancy
- Testicular torsion
- Ovarian Torsion
- Potentially Life-Threatening Tube or Line Malposition/Misplacement - Pneumotosis Intestinalis – MD decision to call if critical!
- Pneumotosis Intestinalis
- Pneumopericardium
- Cervical Spine Fracture

Review/Revision: January 2012

Dictation Criteria: Please follow instructions below for dictating critical results:

1. Call report immediately, or within 30 minutes of interpretation (*J.C. Rule*)

2. Reports must be called to one of the following caregivers : MD, DO, PA, NP, RN

3. In the "IMPRESSION" – radiologist to include:

   - Dictate "CRITICAL OUTCOME"
   - Dictate "NAME" of person called (*no informal titles*)
   - Dictate "TIME" called
   - Dictate "RAV" was performed with an RN

Note the following:

- No time given of call – equates to non-compliance.
- RAV with MD, NP, DO, or PA – is assumed through dialogue.
- RAV with RN – radiologist should verbally acknowledge and have RN read-back understanding of the critical outcome before ending the call.

4. Important!!! – Click and drag the study to the Critical Result Folder in IDX so a faxed report can be sent as follow-up.

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 14

Intensive Care Unit

14. "**Intensive Care Unit.** There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources to resuscitate and monitor injured patients."

Narrative Response and Discussion

The requirements of section 14 are met with a signed letter of commitment from Community Hospital South's ICU Nurse Manager affirming that the patient/nurse ratio will not exceed 2:1 when caring for trauma patients. The ICU has also included a copy of their orientation checklist showing competency to care for patients with neurosurgical injuries as well as a copy of the ICU equipment list.

Community
Health Network

Community Hospital South
Emergency Department
1402 E. County Line Road
Indianapolis, Indiana 46227-0963
317-887-7200 (tel)
eCommunity.com

June 24, 2014

William C. VanNess II, M.D. – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

SUBJECT: Community Hospital South's application for "in the ACS verification Process" for Level III Trauma Center designation.

The purpose of this correspondence is to inform the committee that I serve in the role of Nurse Manager of the Intensive Care Unit. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center requirements. Our team will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

As Nurse Manager I understand that my role is to ensure a patient/nurse ratio does not exceed 2:1 for trauma patients. I also affirm that our intensive care unit has the appropriate resources to resuscitate and monitor injured patients. Enclosed is a list of the Intensive Care Unit's Scope of Service as well as readily available equipment.

Respectfully,

Tony Reynolds R.N., BSN, CCRN
Nurse Manager
Intensive Care Unit

Edward Diekhoff FACS

Edward Diekhoff M.D., F.A.C.S
Trauma Medical Director

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QUALITY-SAFETY MANAGEMENT
SCOPE OF SERVICE PLAN FOR THE
CHS INTENSIVE CARE and PROGRESSIVE CARE UNITS

Scope of Service

The purpose of this document is to provide the operational link to the Network Organizational Performance Improvement and Safety Plan.

Mission: With caring and compassion, we continually strive to improve the health and well being of those individuals in Central Indiana who entrust their care to us.

This plan represents the clinical support service for Intensive Care and Progressive care.

Goals of Patient Care Service: These goals are representative of the Intensive Care and Progressive Care Units at Community Hospital South. The units are combined Medical/Surgical units whose purpose is to provide safe and effective care to patients (concentrated in one area) who may be unstable and/or require a high complexity of nursing care. The units are staffed with RNs and multi-skilled ancillary staff and care is delivered in a manner that:

- Delivers exceptional quality of care guided by the following values:
  - SERVICE: Meet or exceed our customer's needs and expectations
  - ENTHUSIASM: Display a positive and energetic attitude
  - RESPECT: Honor the dignity, value, and involvement of others
  - VALUE: Provide high quality services with a continuous awareness of the cost
  - EXCELLENCE: Continuous improvement of our services

- Uses a systematic approach to (1) collect patient health data, (2) analyze the assessment data in determining diagnosis, (3) identify individual expected outcomes for the patient, (4) develop a plan that prescribes interventions to attain expected outcomes, (5) implement interventions identified in the plan of care, and (6) evaluate the extent to which the goals have been achieved.

- Is involved in continuous quality improvement, utilizing a variety of different mechanisms to track, trend, and implement process improvements. These include Focus–PDSA as the framework for planned, systematic assessment and improvement, Go Fast, Rapid Cycle Improvement and Tracking and Trending Outcomes.

- Through the Professional Practice Council, assures that new and current processes are designed, based on (1) the mission, vision, and strategic plan, (2) the needs and expectations of patients, employees, and others, (3) up-to-date sources of information about designing processes, and (4) the performance of the processes and their outcomes in other organizations (norms and benchmarks).

- Is represented on the Critical Care Committee at CHS and is responsible for monitoring the effects of care delivery and patient outcomes. This group monitors processes of care, measures the output of processes, analyzes the effectiveness of care delivery, and/or makes improvements as identified by the group. This structure of multi-disciplinary participants from nursing, medical staff, and other departments of the organization enhance the ability to timely identify and improve areas of concern or interest.

- Are committed to establishing and maintaining a healthy work environment through:

    - Continually striving for proficiency in communication skills
    - Pursuing and fostering true collaboration
    - Being involved in patient care decisions
    - Staffing based on variance in patient needs and acuity
    - Recognizing others for their value to the work organization and accepting recognition
    - Realize that both they and the nurse leaders impact creating and sustaining a healthy work environment

- **Types and Ages of Patients Served:** The Intensive Care and Progress Care Units' focus is on the general Medical/Surgical patient, with a mixture of cardiac, respiratory, trauma, and surgical cases. Patients who are unstable, require intensive treatment modalities, are at risk for requiring immediate intensive treatment, or who require intense nursing care may be admitted to the Intensive Care Unit. Any patient 14 years of age or older may be a candidate for admission to the ICU or PCU.

- **Scope and Complexity of Patient Care Needs:** Total patient care is provided and/or supervised by an RN staff that is ACLS trained within one year of employment. Ancillary staff provide care where appropriate. The scope of care includes use of the nursing process, patient/family teaching, intravenous therapy administration, medication and treatment administration, implementation of physician orders and environmental control for patient safety. Complexity of patient care needs may include, but is not limited to (1) ventilator care, (2) invasive monitoring, (3) titration of critical care medications, (4) peritoneal dialysis, and (5) hemodialysis, (6) drug therapy not done on units outside of the Intensive Care and (7) CRRT (continuous renal replacement therapy).

The units' organizational plan for Community Hospital South interfaces with the Nursing Departments' organizational plan and is as follows:

1) The Director is a registered nurse with 24-hour accountability for the units. The Director reports to the Vice President of Nursing at CHS. The Director is accountable for the fiscal management of the unit, the management of personnel and is responsible for the direction of patient care.
2) The Nurse Manager (NM) is a registered nurse with 24 hour accountability for the units. The NM reports to the Director of the unit. The NM provides delegation, supervision, and direction to licensed and non-licensed personnel as assigned.
3) The Care Manager is a registered nurse responsible for direct patient care of assigned patients. The Care Manager reports to the Nurse Manager. The care manager is accountable for functioning within the guidelines of the Indiana State Board of Nursing Standards for the Competent Practice of Nursing.

Unit Description:

The ICU is a 12 bed unit. The floor plan is rectangular and open in nature. There are work stations outside of the patient rooms allowing full visibility of the patient. The ICU is equipped with 12 private rooms with breakaway glass doors. Four rooms have negative air flow capabilities. All rooms have bedside and central EKG, hemodynamic monitoring, respiration monitoring and BIS monitoring. All rooms are equipped with suction, 0_2, medical air, call lights, emergency outlets, televisions and phone jacks. All are ventilator capable. Hemodyalisis can be performed in any room with a portable R.O. machine. PCU has 24 private rooms. There are two negative airflow rooms in PCU. All PCU rooms have bedside monitors. Six of the PCU rooms can be used as an overflow for ICU in that they are equipped with additional suctioning equipment.

Emergency Carts: There are four Code Blue carts; two in ICU and two in PCU. Each one is equipped with external pacing and hands-off defibrillation. Each unit's carts have a respiratory box for emergency airway management. Pharmaceutical supplies in the Code Blue carts are monitored and maintained by Pharmacy. It is the responsibility of Nursing to notify Pharmacy when the pharmaceutical supplies need restocked after use. The respiratory box is maintained by the cardiopulmonary department. The general non-pharmaceutical supply trays are supplied by central supply. Nursing is responsible to notify central supply of need for restocking after use. Defibrillators are checked per vendor recommendations and routine maintenance by the clinical engineering department.

Remote Telemetry: The Heart Station department, located within the PCU Unit, is responsible for the surveillance of all remote telemetry on the Medical /Surgical areas on a 24/7 basis, as well as all hard-wire and soft-wire monitors on the Intensive and Progressive Care units.

Medication Room: Pyxis machines are located on each unit in secure Medication Rooms. Each unit has PAR and Equipment Rooms to house IV supplies as well as other supplies needed for the functioning of the unit. These rooms remained locked at all times.

Communication: The ICU and PCU work in a cooperative manner with other hospital departments on a continued basis to keep patient care needs as top priority. Both units are supplied with a fax machine, computer access for electronic chart retrieval, email and regular mail for all employees as well as Vocera badge communication. There is also a pneumatic tube system on each unit.

Extent to which the level(s) of care or service provided meets patient's needs:

Opportunities for improvement are identified through on-going assessment of quality indicators. These indicators may be communicated in a variety of ways. The Quarterly Nursing Report Card provides a very detailed assessment of nursings' areas of opportunity and /or success as related to patient outcomes. Patient satisfaction surveys are reviewed every month with quarterly graphs designating key drivers and their scores posted for staff. These indicators may be discussed at the site level at the Professional Practice Council. The Medical Director for each site is responsible for directing the medical care of the patients while they are located in critical care. This communication may be either through direct care or in collaboration with other physicians. Communication from physician to physician, rather than nurse to physician is preferred with consultations.

Appropriateness, clinical necessity and timeliness of support services provided directly by the organization or through referral contacts:

Admitting Office: Patient assignments are handled between the Admitting Office and the Resource Coordinator Administrator on staff. The attending physician must make requests for admission to the units.
Resource Coordinator Administrators handle bed control for days and nights. In the absence of an RCA, the Nurse Managers or Patient Care Coordinators handle all bed placements after being notified of potential admissions from the admitting office.

Case Management: Case Management is utilized in the Intensive Care and Progressive Care settings to assure a continuum of care. Rounds are made in the units daily to assess for patient/family need and to communicate with the staff.

Dietary Department: All dietary orders are sent to dietary via computer. Dietary carts are transported to the unit where the dietary personnel deliver patient trays. Patients are directly assisted with their meals by the nursing staff. A nutritional screen is completed by nursing on all patients at admission. Those patients who have low serum albumen, diagnosis related to gastrointestinal disease, or are on a ventilator, receive a nutritional consult by dietary. A dietary consult may also be indicated based on the nutritional

screen completed by nursing. The consult is completed within 48 hours. Ventilator patients will have a completed profile within 24 hours. Nutritional status of ICU patients is monitored on a regular basis.

Cardiopulmonary Service: Therapeutic orders and treatments are processed via the computer. All treatments are initiated and continued by the cardiopulmonary personnel on a 24-hour basis. (Incentive spirometry is managed by both Cardiopulmonary and the nursing staff.) Cardiopulmonary staff are responsible for the monitoring and changes made for all ventilator patients. Nursing works very closely with Cardiopulmonary and, when patients are weaned from the ventilator, this is done as a team effort.

Materials Management: The units maintain a pre-determined amount of chargeable and non-chargeable items. UHS personnel monitor supplies for inventory and lost charges. Specific supplies may be requested by phone or computer and are received promptly. UHS staff collects used equipment from the soiled holding areas for reprocessing.

Laundry: Linen is delivered to the units daily with additional requests honored. Soiled linen is placed in the soiled utility rooms, picked up daily, and is handled with standard precautions.

Engineering Services:
Staff dials 5-4000 for maintenance or Clinical Engineering. Preventative safety checks are done as determined by Clinical Engineering and/or UHS. Each piece of equipment has a Preventative Maintenance identifier to indicate when the clinical equipment is due for routine inspection. History of the equipment may be accessed through the computer.

Environmental Services: Environmental Services is responsible for the routine and terminal cleaning of discharge units and maintaining a clean environment.

Medical Records: Previous patient records are available to the units when a patient is readmitted. Health Information Management will request records from other institutions and copy information to be sent with patients upon transfer to another institution. Records on file since Centricity are available through Visit Management-Viewing a Past Visit. Also, computerized retrieval via Sovera is available.

Laboratory Services: Are outsourced to Mid America Labs. Nursing draws all specimens and obtains blood and blood products from the lab. Quality Control for P.O.C. testing is maintained in the lab.

Radiology: Orders are processed via computer. During day shift, patients are transported to radiology by transport technicians. During off hours/off shifts, nursing transports patients. Radiology has Special Procedure nurses in the department to monitor patients during any type of intense procedure. The critical care beds are also radiolucent for bedside radiographs or C-arm procedures when necessary.

Emergency Department: The hospital intensivist physician responds to all code blues called from the ICU. Patient admissions coming from the ED will have an RN accompany them to ICU. Report is given prior to the patient being transported to the Critical Care unit. This may be via telephone or face to face. In any instance, there is time allotted for questions regarding the care of the patient. If an inpatient or family member should sustain an injury, medical attention is offered in the ED. Staff may also obtain care should an incident occur.

Surgical Services: The ICU RN will accompany the ICU patient to surgery if necessary. Once the patient is in surgery, the personnel in surgical services assume responsibility of the patient. When it becomes necessary for the patient to go directly to the ICU after surgery, the patient is recovered in the ICU by either Recovery Room staff or ICU staff.

Pharmacy: Pharmacists make rounds daily Monday – Friday, and are available for questions or information as needed. Medication and intravenous therapy orders are sent to Pharmacy by fax, phone or direct communication. Intravenous solutions that contain medication are ordered from pharmacy, while intravenous solutions that do not contain medication are stocked by Materials Management. The RN utilizes a bedside computer based medication record system in conjunction with the Pyxis dispensing units. In addition to the Pyxis, medications may also be sent via a secure Pneumatic Tube system available on each unit. Access to the pharmacy and the pharmacy staff is available 24/7.

Referral contacts: These contacts are made by communication between the sending physician and the receiving physician. Once bed availability is confirmed, the sending nurse will call report to the receiving nurse prior to transfer. The need for referral is made either by the attending physician or at request of the family.

Availability of necessary staff: Competent Practice of Nursing: Nursing care responsibilities are assigned to a nursing staff member in accordance with qualifications of the nursing staff member and the needs of the patient. The Director, or designee, does staffing schedules on a bi-weekly basis or as determined by the unit leadership. The schedule is based on a master-staffing plan.

Nurse-Patient ratio is usually 1:2 in the ICU, with a Nurse Patient ratio of 1:3 or 1:4 in the PCU. The Level of Care classification (acuity) is done per patient to help project the needs of the next shift and the next day, or as often as needed.

Patient Care Coordinators are assigned Charge duties based on educational preparation and assessment of current competence. The nursing staff must demonstrate ongoing competence, or skills credentialing, in areas relative to performance expectations. The purpose of the skills credentialing is to facilitate safe and effective patient care through the validation of technical skills, using indicators to prioritize these skills. Skills credentialing will occur on an ongoing basis, such as every four months, or during one "Skills Day".

For the new employee, a unit specific orientation program is designed to assess each individual's current level of competency through the use of a skills inventory. Formal unit specific orientation is done through an established preceptor program. Time for completion usually requires from 4-8 weeks, depending on the individual's previous education and experience. It is suggested that RNs have at least one year of clinical experience on a general medical/surgical unit prior to orienting to ICU. All staff are required to attend mandatory education involving infection control, fire and hazmat safety and CPR.

Personnel must have completed formal education requirements; general orientation, unit specific orientation, and special training that may be necessary to comply with patient care needs. ICU and PCU nurses will obtain their ACLS certification within their first year of employment. Personnel are permitted to "float" to other units but do not assume the direct operations of said unit.

Recognized Standards or guidelines for practice: American Association of Critical Care Nurses provide "Standards for Acute and Critical Care Nursing Practice" to guide us in our practice. These standards address assessment, diagnosis, outcome identification, planning, implementation and evaluation. A copy of the standards is found on-line. Each employee is responsible to provide nursing care based on Policy and Procedures, Guidelines of Practice, and AACN Standards for Nursing Care of the Critically Ill, while functioning within the guideline of the Indiana State Board of Nursing Standards for the Competent Practice of Nursing. The Director is responsible for the provision of appropriate educational and policy manuals to assist the staff. If problems or questions should arise, the established chain of reporting is followed. The unit Director and registered nurses assist in the development of unit specific guidelines.

Methods that are used to assess and meet patient needs, including staffing effectiveness indicators as appropriate: Please see Scope of Assessment. Staffing effectiveness indicators are monitored and evaluated quarterly. These are reported on the Nursing Report Card.

Our focus to meet patient needs is on seven domains:

- Patient & Family Experience
- Clinical Performance
- Workforce
- Financial Management
- Leadership
- Process Management & Tools
- Technology & Design

Staffing Effective Indicators

Staffing effectiveness is another "measure" utilized to assess and address nurse-sensitive outcomes.

The phrase 'staffing effectiveness' refers to the intersection of patient outcomes and adequate staff. Each quarter every clinical unit reports their particular data which is then shared with the network. This year, all the ICUs will be using the same measures for the first time and have chosen the following:

- Human resource indicator: % of RN activity (turnover, transfers etc)
- Clinical indicator: Skin initiative
- Human resource indicator: HPPD (hours per patient day) that means actual bedside hours delivered to patients
- Clinical Indicator: Fall rate (with and without injury)

These indicators may or may not be the best indicators of the intersection of effective clinical outcomes and staffing but they do build a correlation between measurable patient events and the staffing levels and stability of the staff.

Identification of major internal and major external customers: Our major external customers are patients, patient's families, significant others, physicians and their office staff, clergy, facilities to which we transfer our patients, and the community at large. Our major internal customers are Patients, Emergency Department, Cardiopulmonary, Case Management, Dietary, Laboratory, Radiology, Nuclear Med, Pharmacy, Admitting Office, Materials Management, Clinical Engineering, Surgical Services, Med/Surg units, Environmental Services, and Medical Records. (HIM)

Education of the patient: Education begins on admission to the ICU and PCU as the patient data base is completed, with orientation to the pain scale, the room and routine of the hospital. An individualized plan of care which includes educational needs, is formulated at time of admission, initiated and implemented. Reassessments are completed daily or more often, as needed, using the multidisciplinary goal sheets. Methods of teaching include, but are not limited to, verbal instruction, written materials, demonstrations, return demonstrations, audio-visual aides, and handouts of written information.

Safety Management: It is the responsibility of the employees to participate in the Safety Management Program through compliance with safety policies and procedures and attendance at safety in-services. Employees must identify and refer safety related issues to their Managers. Employees must perform their job responsibilities in accordance with established safety policies and procedures, and in accordance with JCAHO seven patient safety goals and IHI 100,000 lives campaign.

Safety initiatives include participation in the TICU (VHA/IHI initiative on the transformation of the ICU) on a national level. Other initiatives include utilization of the

BIS monitor in the ICU, End of Life care and tracking primary bacteremia in central lines. Staff participate on various committees as needed to improve patient care issues. Other initiatives include, but are not limited to the following:

- VAP Bundle
- Sepsis Bundle
- Critical Care Consults
- Bedside Report
- Galaxy Fall Initiative
- Skin Initiative
- CAUTIs
- Medication Reconciliation
- Multidisciplinary Rounds
- Purposeful Rounding
- Permanent Hand-Off

The Vice President of Nursing and the Director meet with the ICU and PCU Nurse Managers to discuss patient care issues, staff and interdepartmental issues. Information is shared and recommendations are made.

Staff meetings are held to maintain open channels of communication, to exchange ideas, to review quality activities, and to resolve problems within the nursing unit. They are normally conducted monthly by the Nurse Managers/Director or designee. Communication is also maintained through Voice Mail, news fliers, email, SharePoint web communication and electronic bulletin boards.

Original Plan Adopted and Approved: 2011
Approved By:

_____
Kerry Sawin, MBA, RN
Vice President of Nursing
Community Hospital South

COMMUNITY HOSPITALS INDIANAPOLIS
ORIENTATION DOCUMENTATION RECORD

Critical/Intensive Care
RN

Name:_____ Orientation Start Date:_____ Unit/Dept:_____

Hospital I.D. #:_____ Facility:_____

Most Recent Work Experience and Dates:_____ Education and Dates:_____

The employee is responsible for the timely and accurate completion of the Orientation Documentation Record. Each unit/dept. will have a designated place for the Record during the employee's orientation. The completed documentation record is placed in the employee's permanent personnel file in Human Resources within 6 months of the orientation start date.

A competency-based orientation plan will be developed within the framework of the employee's self-assessment, educational background, work experience, and the role summary.

Competency Statements with Expected Behaviors are the knowledge and skills that an employee must demonstrate for safe and effective health care delivery. Validation will be done in a lab/classroom or clinical/work area, depending on the specific behavior.

Self-Assessment column will be completed within the first week of orientation by employee if he/she has similar work experience. A check mark will be placed in one of the three columns for each competency statement. The non-experienced employee may leave self assessment section blank. Any skills or tasks assessed as "no experience" or "need practice/review instruction" will require direct observation when performing.

Column 1 - No experience or minimal experience
Column 2 - Need practice/review/instruction of CHI policies and procedures and/or with CHI equipment
Column 3 - Can do (indicates competence based on previous experience)

Instructed column will be initialed and dated when the instruction or self learning activity has been completed. For any competency checked "can do", instruction may be omitted. However, validation of the competency is necessary.

Validated column will be initialed and dated as the competency is demonstrated in the lab/classroom and/or clinical/work area by the person who validates the competency. Validation means the orientee can demonstrate knowledge or perform skills according to CHI standards/policies/procedures without guidance from the person observing. If instruction is required the experience is to be considered instructed rather than validated.

No clinical validation is to occur until valid RN license is obtained. Do not complete the column identified as "validated to clinical/work areas" prior to RN licensure.

The words, "Not Applicable" or "NA" may be written across the columns on an individual's record for any competency deemed required for some but not all members of a work team or department.

Persons who provide instruction and/or validation in addition to writing initials will sign full name one time on the last page of this Orientation Documentation Record.

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			
Nursing Process/Clinical Practice						
I. Complies with safety and emergency procedures consistent with hospital policies.						
A. Demonstrates infection control measures in the clinical setting by:						
1. Utilizing isolation techniques						
2. Utilizing universal precautions						
B. Demonstrates proper use and documentation of restraints.						
C. Verbalizes Code Blue responsibilities.				CLN-2005 - CPR		
D. Demonstrates crash cart responsibilities by:						
1. Performing monitor/defib operational checks.				CLN-2005 CPR, Attachment C		
2. Performing crash cart check.				CLN-2005 CPR, Attachment C		
E. Verbalizes appropriate electrical safety procedures.				Read E-003 Electrical Safety Guidelines		
F. Verbalizes/initiates emergency protocols as appropriate.				Read NPP: P-001		
II. Documents required information consistent with CHI policy and procedure.						
A. Patient Flow Sheet						
B. Multidisciplinary Note						
C. Patient Care Pathway						
D. Transcribes doctor's orders						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
E. Utilizes CIS Technologies						
1. Assessment Form						
III. Assesses patient data to identify health care needs.						
A. Collects assessment data using Nursing Admission Data Base.						
B. Performs ongoing assessment according to CHI policy and procedure and level of care guidelines.						
1. Head-to-toe						
2. Systems Review						
3. Focused Reassessment						
4. Completes Basic Physical Assessment CAP						
C. Correlates lab values with clinical assessment and initiates appropriate interventions.						
1. Potassium						
2. Troponin/CPK						
3. PTT/INR/ACT						
4. ABGs						
5. Drug levels						
6. Other labs relevant to patient's primary/admitting diagnosis, concurrent medical conditions or past medical history.						
D. Assigns level of care appropriate for patient needs.				CLN-2081		
IV. Plans nursing care from identified nursing diagnoses/collaborative problems on focused needs.						
A. Follows plan of care as outlined on Patient Care Pathway.						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
B. Recognizes and documents variances from Patient Care Pathway.						
V. Implements a plan of care based on patient needs to promote, maintain and restore health or support a peaceful death.						
A. Coordinates and/or provides nursing care for the patient requiring transfer to greater or lesser acute care area.						
B. Coordinates patient care and completes appropriate paperwork for patient transferring into unit						
A. Passport to Transport						
B. Hand off communication						
C. Performs and documents patient discharge using appropriate forms.						
1. To home						
2. To another healthcare facility						
3. To another unit within the hospital						
4. Patient discharge/transfer/referral form, physician medication orders & discharge instruction sheet.						
D. Provides care for patient requiring surgical procedure:						
1. Pre-op						
2. Post-op						
E. Performs and documents technical skills according to hospital policies:						
1. Bedside blood glucose monitoring						
2. Medication Administration:						
a. Proficient use of pyxis machine						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
b. Consistently utilizes two patient identifiers.						
c. Controlled substances, administration, waste & discrepancies						
d. Epidural/Intrathecal						
e. Eye Drops						
f. IM						
f. Insulin Administration:						
(1) Single dose						
(2) Mixed dose						
(3) Sliding scale						
(4) Continuous infusion						
(5) Insulin Pumps						
g. Intermittent IV Infusion (IVPB)						
h. IV Push						
i. Metered dose inhaler						
j. NG/G-tube/J-tube/OG						
k. Oral						
l. PCA						
m. SQ/Intrafat						
n. Sublingual						
o. Suppository						
p. Topical/patches						
q. Z-tract						
3. Intravenous Procedures:						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
a. Administers blood/blood products utilizing two patient identifiers.						
b. States s/s of blood transfusion reaction and intervention taken						
c. Administers TPN, PPN, intralipids						
d. Holds pressure to venous and arterial puncture sites						
e. Site check						
f. System check						
g. Sets up/flushes (gravity) IV tubing						
h. Sets up infusion pumps/tubing, including channel labels and guardrails						
i. Peripheral Sites:						
(1) Starts IV						
(2) Changes tubing						
(3) Discontinues site						
(4) Dressing change						
(5) Flushes saline lock utilizing positive pressure						
j. Central Venous Catheters:						
(1) Assists with placement						
(2) Changes caps						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(3) Changes tubing						
(4) Dressing change – multilumen cath						
(5) Discontinues multilumen cath						
(6) Discontinues PICC						
(7) Flushes capped ports using positive pressure and appropriate heparin flush						
(8) Draws blood from CVC's/PICC's						
(9) Draws blood from PICC						
k. Peripheral Blood Draws:						
(1) Routine						
(2) Blood culture						
(3) T & C						
4. GI Procedures:						
a. Naso/Orogastric/Enteral Tubes						
(1) Insertion						
(2) Feedings:						
(a) Intermittent						
(b) Continuous						
(3) Irrigation/maintenance						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
b. Ostomy Care						
(1) Identifies indications for referral to Enterostomal Therapists						
(2) Applies ostomy appliances						
c. Collects stool sample						
5. Genitourinary Procedures:						
a. Obtains urine specimens						
(1) CCMS						
(2) Cathed specimen						
(3) From indwelling catheter						
(4) C & S Vacutainer						
b. Applies exdwelling catheters						
c. Inserts catheters						
(1) Straight						
(2) Indwelling						
d. Verbalizes indications for use for bladder scanner						
e. Performs assessment and identifies safety measures for patient with AV fistula/graft						
f. Provides care for patients with and/or receiving:						
(1) Permacath						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(2) Temporary dialysis catheter						
(3) CAPD						
(4) Hemodialysis						
(5) Continuous renal replacement therapy						
6. Respiratory Procedures:						
a. Suctions tracheostomy (cath & glove)						
b. Performs trach care						
(1) disposable						
(2) nondisposable						
c. Changes trach ties						
d. Administers oxygen via appropriate device						
(1) Nasal cannula						
(2) Mask						
a. venturi						
b. non-rebreather						
c. simple						
(3) Trach collar						
f. Obtains sputum specimen:						
(1) Expectorated						
(2) Suctioned with mucous trap						
g. Cares for patient with chest tube:						
(1) Assists with insertion						
(2) Discontinues						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(3) Maintains & trouble-shoots system						
(4) Verbalizes appropriate intervention for disconnected tube.						
h. Correlates pulse oximetry measurements with assessment findings and initiates appropriate interventions.						
i. Performs radial arterial puncture for blood gases (with Allen's test prior to puncture).						
j. Provides care for patient requiring mechanical ventilation						
(1) Assists with intubation procedure						
(2) Describes various modes of ventilation and their implications (CMV, SIMV, CPAP, PS, PEEP)						
(3) Troubleshoots common problems associated with vent patient (gagging, biting ETT, resisting ventilation, emesis, skin breakdown, life threatening vent alarms)						
(4) Identifies appropriate indicators for use of manual resuscitator.						
(5) Utilizes vent pathway						
(6) Manages care of vent patient utilizing VAP protocols						
(7) Demonstrates proper use of continuous in-line suction catheter						
(8) Demonstrates retwill/retie of endotracheal tube						
(9) Collaborates with respiratory therapy in utilizing weaning protocol						
(10) Assists with/performs extubation						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(11) Cares for patient immediately post-extubation						
k. Cares for patient on BiPAP						
7. Skin Care Procedures:						
a. Provides care for patient at risk for or with actual skin impairment.						
(1) Assesses risk using Braden Scale						
(2) Wound assessment						
(3) Impaired skin integrity report						
b. Performs dressing change:						
(1) Clean						
(2) Sterile						
(3) Wet to Dry						
c. Removes sutures/staples						
d. Maintains/removes wound drains						
(1) Hemovac						
(2) Jackson-Pratt						
e. Collects wound cultures per protocol or M.D. order						
f. Provides care for patient requiring body temperature control with cooling/warming blanket and selects appropriate device per policy.				NPP-W-004 NPP-H-009		
8. Neuro/Ortho Procedures:						
a. Provides care to patient with EVD (external ventricular drain).						
b. Identifies signs/symptoms of stroke/TIA and initiates Code Stroke Protocol as appropriate.						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
c. Recognizes and describes seizure activity.						
d. Initiates/maintains appropriate safety measures for patient at risk for or with actual seizure.						
e. Administers parenteral Dilantin.				NPP I-14		
f. Provides care and education for patient requiring neurological testing/procedures:						
(1) On unit (EEG, LP)						
(2) Off unit (MRI, CAT scan, angiogram)						
g. Performs neurovascular checks						
h. Bi-spectral monitoring (BIS) monitor/Train of four (TOF)						
9. Cardiovascular Procedures						
a. Performs cardiovascular assessment:						
b. Initiates/maintains cardiac monitoring.						
(1) Applies electrodes in correct configuration.						
(2) Sets monitor alarms appropriately.						
(3) Communicates with heart station/CMT.						
(4) Obtains and documents cardiac rhythm strip each shift and with rhythm changes.						
c. Verbalizes indications for and discusses the implications of findings for the following cardiac tests:						
(1) Thallium, echo, treadmill, tilt table testing						
(2) Cardiac Cath						
(3) Post-cardiac Cath with sheath						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
a. Performs removal of arterial sheath.						
b. Performs removal of venous sheath.						
(4) Post-cardiac Cath without sheath						
d. Provides care for patient receiving cardiovascular medication infusions.						
(1) Verbalizes indications and normal dose ranges for:						
(a) Antiarrhythmics 1.						
(b) Inotropics/vasoactives						
(c) Vasodilators/antihypertensives						
(d) Thrombolytics/anticoagulants						
(2) Calculates & documents infusion rates (mcg/Kg/min or mcg/min) every shift and with changes.						
(3) Titrates medication to achieve desired effects.						
(4) Completes vasoactive drug calculation CAP						
e. Provides care for patient requiring invasive hemodynamic monitoring						
(1) Line insertion						
(a) Bag/pressure tubing set-up						
(b) Monitor set-up						
(c) Patient preparation						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
(d) Set-up sterile field and assist with placement of:						
1. Arterial line						
2. PA catheter/$SCV0_2$/flowtract						
3. Central venous catheter/central line						
(2) Maintenance – art line						
(a) Zero balance/leveling/set alarm limits						
(b) Identifies normal waveforms and troubleshoots deviations						
(c) Blood draw and flush						
(d) Obtains readings						
(e) Compares readings to cuffed BP measurements and correlates to clinical assessment						
(f) Verbalizes risks/complications and preventative measures						
(3) Maintenance – PA catheter/ $SCV0_2$/flowtract						
(a) Zero balance/leveling/set alarm limits						
(b) Identifies normal waveforms and troubleshoots deviations						
(c) Blood draw and flush						
(d) Obtains readings						
1. PA pressures						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
2. Wedge						
3. Cardiac output/index						
4. SVO_2						
5. Stroke volume						
(e) Prints hemodynamic profile						
(f) Correlates readings with clinical assessment and initiates appropriate interventions						
(g) Verbalizes risks/complications and preventative measures						
(4) Line Removal						
(a) Arterial line						
(b) PA catheter/ $SCV0_2$/flowtract						
(c) Catheter tip culture						
VI. Develops and implements a teaching plan in order to restore, maintain, and promote health.						
A. Identifies survival skills/educational needs of patients.						
B. Reinforces patient education						
C. Documents patient education on Patient Care Pathway/patient education record.						
VII. Evaluates patient response to care and revises plan of care to meet desired patient outcomes.						
In collaboration with preceptor:						

Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
A. Performs 24-hour review of plan of care and revises plan as necessary.						
B. Revises/updates discharge plan based on patient's needs.						
C. Analyzes achievement or non-achievement of outcomes/goals on Patient Care Pathway and initiates action plan as needed.						
VIII. Addresses age specific needs in delivering care across the health/illness continuum.						
A. Considers the impact of illness and/or hospitalization on the patient's developmental/life stage.				Date passed State Boards		
B. Implements nursing interventions appropriate to age/developmental stage of patient.						
Professional Development **IX. Performs nursing leadership role as defined by unit expectations.**						
A. Delegates specific aspects of patient care to other nursing staff and ancillary personnel based on their level of education and abilities.						
B. Identifies/communicates specific opportunities for quality improvement.						
X. Actively participates in the development of professional competence and practice.						
A. Identifies own learning needs and communicates needs/goals to preceptor, clinical manager/director or resource educator.						
B. Responds to constructive feedback and suggestions in non-defensive manner.						
XI. Supports the care manager role as defined by unit expectations.						

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Competency Statement with Expected Behavior	Self Assessment: No Experience	Self Assessment: Need Practice/ Review/ Instruction	Self Assessment: Can Do	Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
A. Identifies responsibilities of the care manager and other care team members.						
XII. Uses established channels of communication and collaboration to support the achievement of patient and CHI goals.						
A. Communicates effectively with other members of the health care team:						
1. Reports patient status to Care Manager and other team members.						
2. Takes telephone/verbal orders from physician						
3. Gives accurate shift report.						
4. Utilizes patient call system and paging system.						
5. Expresses self in diplomatic manner.						
B. Communicates effectively with patients/families:						
1. Introduces and identifies self to patient/family						
2. Keeps patient/family informed						
3. Recognizes and responds appropriately to patient/family feelings and related behaviors.						
XIII. Actively pursues competency in care manager prerequisites in order to assume the care manager role within the specified time frame as defined by the Clinical Integration Teams.						
A. Registered for Care Management Core Class						
REFER TO GSN TRAINING FOR CARE MANAGER ROLE COMPETENCY ASSESSMENT AND DEVELOPMENT GUIDE.						

RN Crit Intensive Care

I acknowledge that:

1. I am responsible for utilizing Community Hospital policies, procedures, and standards.
2. I am accountable for my ongoing professional development and utilizing resources as needed.
3. I am responsible for seeking and utilizing assistance for patient care in which I am not competent and/or experienced.

_____
Date and Employee Signature

Instructors and Validators: (Signatures)	(Initials)	Instructors and Validators: (Signatures)	(Initials)

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Orientation Documentation Record reviewed by: _____
Date and Leadership Signature

Send Orientation Documentation Record to Human Resources to be placed in employee's file within two weeks of orientation completion date and not to exceed six months from orientation start date.

All experiences may not be available for validation of competency during the initial orientation period. List any competencies that have not been validated on a Competency Development Action Plan (Goal) form. Validate these competencies prior to the annual performance appraisal.

Continuation of Orientation Documentation

Utilize this form for documentation of competencies not obtained during initial orientation.

Competency Statement with Expected Behavior	Self Assessment			Instructed Initials & Date	Validated in Lab/Classroom Initials & Date	Validated in Clinical/Work Area Initials & Date
	No Experience	Need Practice/ Review/ Instruction	Can Do			

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Date & Employee Signature

Reviewed By: _____

Date & Clinical Leadership

Send to Human Resources to be filed in employee's permanent record.

Name: **Start Date:**

Preceptors:

	Item #'s	Date Completed	
Tests		Time with Gail	
EKG	#15833		
Vasoactive Drug Calculation	#4164		
ABG intepretation	#4161		
IVIN (insulin gtt calculation)	#15227		
Competency Check Offs (CAP) **Complete in Orientation**			
Physical Assessment	#4166		
ABG stick	#7341		
Blood Administration	#7221		
Defib Zoll monitor	#5021		
Pace Zoll monitor	#5022		
Cardiovert Zoll monitor	#5023		
Central Line Drsg Change	#7561		
12 Lead EKG CAP	#4432		
Central line blood draw	#10565		
Foley Cath insertion	#4444		
Arterial Sheath Removal	#15468		
Purposeful Rounding	#10545		
Bedside Swallow Screen	#16010		
IV Set Up Basic Guardrail Fluids	#5168		
PCA Pump and End Tital CO2 Monitoring	#11505		
IV Set Up IV Heparin	#5298		
Guardrails for Alaris Pump Dopamine	#5142		
Arterial Line Blood Draw (ICU)	#16668		
Epaks **Complete Prior to end of orientation**			
Conscious Sedation	#7281		
ACUTE Coronary Syndrome	#8303		
VAP epak	#9785		
Arterial Sheath Movie	#17445		
Evacuation Chair Video	#15893		
ABG epak	#9565		
MAC 5500	#21095		
Age and Gender Differences	# 8331		
NIHSS (grade 6 pts)	#6263		
Aspiration Screen epak	#13245		

Code Stroke ACT fast (Hospital Orientation)	#16008		
Urological Improvement	#23310		
Stroke Standards	#24610		
Stroke Clinical Practice Guidelines	#24990		
Nsg Care of Acute Stroke Patient	#16012		
Stroke Risk Factors 2014	#26912		
2014 FAST Awareness	#26697		
Subarachnoid Hemorrhage	#21090		
TpA Adminstration	#12405		
Blood Transfusion **(exp RN)(orientation)**			
ICP monitoring (ICU)	#18046		
Camino Monitor (ICU)	#17683		
Classes & Misc			
ICU Core Classes Register (recommended)			
Orientation Guide IN			

Stroke staff education 2014

Staff	Education in MyLearning	Number	Frequency
RNs	Code Stroke ED Act FAST	9347	Annually
	NIHSS class Group A	18629	Orientation
	Nursing Care of Acute Stroke patient- Journal article	16012	
	Online NIHSS scale reassessment (NSA site) 6 patients	6263	Annually
	Stroke Clinical Practice Guidelines	24990	Orientation and annually
	Stroke Risk Factors 2014	26912	Annually
	Stroke Standards	24610	Annually
	tPA administration for Ischemic stroke	12405	Annually
	Aspiration screening	13245	Orientation
	2014 FAST awareness	26697	Orientation and annually
	Intracranial Pressure Monitoring	18046	
	Subarachnoid hemorrhage	21090	
ICU/PCU RNs	NIHSS class Group A	18629	Orientation
	Code Stroke in-house Act FAST	16008	Annually
	Nursing Care of Acute Stroke patient- Journal article	16012	
	Online NIHSS scale reassessment (NSA site) 6 patients	6263	Annually
	Stroke Clinical Practice Guidelines	24990	Orientation and annually
	Stroke Risk Factors 2014	26912	Annually
	Stroke Standards	24610	Annually
	tPA administration for Ischemic stroke	12405	Annually
	Aspiration screening	13245	Orientation
	2014 FAST awareness	26697	Orientation and annually
	Intracranial Pressure Monitoring	18046	Annually
	Subarachnoid hemorrhage	21090	Annually
Neuro unit RNs	NIHSS class Group A	18629	Orientation
	Code Stroke in-house Act FAST	16008	Annually
	Nursing Care of Acute Stroke patient- Journal article	16012	
	Online NIHSS scale reassessment (NSA site) 2 patients	6263	Annually
	Stroke Clinical Practice Guidelines	24990	Orientation and annually
	Stroke Risk Factors 2014	26912	Annually
	Stroke Standards	24610	Annually
	Aspiration screening	13245	Orientation
	2014 FAST awareness	26697	Orientation and annually
	Subarachnoid hemorrhage	21090	
Other clinical staff	2014 FAST awareness	26697	Annually
	Code Stroke in-house Act FAST	16008	Annually
Hospital support staff	2014 FAST awareness	26697	Annually
Hospital leadership	2014 FAST awareness	26697	Annually
Volunteers	2014 FAST awareness	26697	Annually

ICU Unit Equipment List for Trauma Certification

Equipment available in ICU:

- Rooms have GE monitoring system with capability of and monitor capture to the EMR
  - Lead II ECG monitoring
  - O2 Saturation
  - Respiratory Rate
  - 12 lead ECG
  - P.A., CVP, C.O. /C.I.
  - Arterial line pressures
  - Intra-abdominal Pressure
  - Intracranial pressure
  - BIS monitoring

- Code Cart with Zoll monitoring/Defibrillating/ transcutaneous pacing capability
- Transport cart with Zoll monitoring/Defibrillating/ transcutaneous pacing capability
- Transvenous Pacing
- Glidescope for visualization during intubation
- Ventilators: Galileo Gold/ASV
- End tidal CO2 monitoring
- Bipap
- Peripheral Nerve Stimulator (TOF)
- SonoSite portable Ultrasound for Central Line placement
- Neuro Cart: All supplies for both Becker or Camino ICP and/or EVD placement
- Camino Monitor
- Vigileo Monitor for PreSep Catheter (ScVO2), Flotrac Sensor (C.O./SVV…)
- Esophageal Doppler (hemodynamic monitoring)
- Pyxis Medication delivery system
- Vocera Communication devices on all staff
- Cortrak: Enteral Feeding
- Doppler for PV assessment
- Bladder Scanner
- Intra-abdominal pressure monitoring capabilities
- Artic Sun for therapeutic hypothermia
- Bair Hugger
- NxStage for CRRT
- IABP
- Airpal for Bariatric transfer
- Trach tray
- Thoracostomy tray
- Chest tube tray

Community Hospital South

Indianapolis, IN

APPLICATION FOR ISDH "IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER STATUS

SECTION 15

Blood Bank

15. "**Blood Bank.** A blood bank must be available 24 hours per day with the ability to type and cross match blood products, with adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), platelets, cryoprecipitate and other proper clotting factors to meet the needs of the injured patients."

Narrative Response and Discussion

The requirements of section 15 are met with a signed copy of the Mid America Clinical Laboratories and Community Health Network Blood Bank Policies. A signed copy of Community Hospital South and the Indiana Blood Center agreement is included. Included are signed letters of commitment affirming compliance with all requirements to meet Level III trauma designation.

Community
Health Network

June 17, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Chief Pathologist, Laboratory, and Blood Bank Medical Director. I am pleased to support Community Hospital South in the effort to complete the "in the process" Level III Trauma Center requirements. We will work together to continue to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that Blood Bank Services are available twenty-four hours per day at Community Hospital South. This service includes the ability to type and cross-match blood products.

I confirm that we maintain an inventory of adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), cryoprecipitate, and other proper clotting factors. We have a contract with the Indiana Blood Center to have platelets, and a wide variety of other blood products delivered to Community Hospital South when needed twenty-four hours per day. These are typically available to administer within 30 minutes to one hour.

Respectfully,

Michael Sever, M.D.
Laboratory Medical Director

Edward J. Diekhoff III, M.D.
Trauma Medical Director

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Community
Health Network

June 17, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital South's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this correspondence is to inform the committee that I serve in the role of Laboratory Manager. I am pleased to support Community Hospital South's effort to complete the "in the process" Level III Trauma Center Requirements. We will work together to demonstrate exemplary trauma care to achieve American College of Surgeons verification as a Level III Trauma Center within two calendar years.

I further understand that my role is to ensure that blood bank services are available twenty-four hours per day at Community Hospital South. We have a contract with the Indiana Blood Center to have platelets, cryoprecipitate, and a wide variety of other blood products delivered to Community Hospital South when needed twenty four hours per day.

Respectfully,

Gabrielle Houston

Gabrielle Houston, MLS(ASCP)
Laboratory Manager

Edward J. Diekhoff III, M.D.
Trauma Medical Director

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Indiana BLOOD CENTER

SERVICES AGREEMENT

PROVIDED BY:

Indiana Blood Center
3450 N. Meridian Street
Indianapolis, IN 46208

PROVIDED TO:

Community Hospital South
1402 East County Line Road South
Indianapolis, IN 46227

This SERVICES AGREEMENT for blood services, blood product services, and/or related testing services is entered into this 1st day of July, 2013 ("Effective Date") by and between INDIANA BLOOD CENTER (hereinafter "Blood Center") and COMMUNITY HOSPITAL SOUTH (hereinafter "Client").

In consideration of the mutual covenants and agreements contained in this Agreement, the parties agree as follows:

I. APPENDICES, EXHIBITS AND RESOURCE MANUAL

A. All Appendices and Exhibits and Addenda attached hereto are hereby incorporated into this agreement.

B. The Customer Resource Manual for Laboratory Testing Services ("Customer Resource Manual"), which may be amended by the Blood center from time to time, referred to in this agreement, is hereby incorporated into this agreement.

II. SERVICES

A. The Blood Center agrees to provide to the Client one or more of the services set forth in Appendices and the Client agrees to pay to the Blood Center the service fees provided for therein as selected below.

- ☒ Blood Services and Blood Products Services and service as described and selected on Appendix A and Exhibits thereto
- ☒ Testing Services and Testing Service Fees as described and selected on Appendix B and Exhibits thereto.
- ☒ Appendix X Committed Volume
- ☐ Addendum A to Services Agreement

B. The Blood Center agrees to provide to the Client consultative services for all tests performed for the Client upon the request of a Client pathologist, or a staff member of the referring physician.

C. Use of Third Party Laboratories

1. The Blood Center may, in its reasonable discretion, use the services of other

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qualified and licensed blood and blood products testing laboratories (individually referred to as "Third Party Laboratory" and collectively referred to as "Third Party Laboratories") to perform any or all of the blood testing services contemplated by this Agreement and as more specifically identified in the Customer Resource Manual.

2. The Blood Center shall maintain or cause its Third Party Laboratories to maintain, as applicable, current and valid government licenses, permits and approvals as required to perform the blood testing services identified in Section III(A).

3. The Blood Center shall ensure that, prior to performing any work, the Third Party Laboratory agrees in writing to be bound by all the terms and conditions of this Agreement to the same extent as if such Third Party Laboratory were the Blood Center. The Client shall be a third party beneficiary of any such agreement.

D. Billing and Payment:

1. The Blood Center shall give the Client thirty (30) calendar days written notice prior to effecting any change in the price/rate schedules for blood products, blood products services, and testing products and services.

2. The Blood Center shall invoice the Client at least monthly for all services rendered under this Agreement. All laboratory invoices shall identify the laboratory services rendered by patient name and/or identification code, and testing date.

3. The Client shall make the payment within thirty (30) calendar days of the invoice date.

4. The Client shall remit payments to:

Indiana Blood Center

This address should be used for all First Class Mail routed through the US Postal System. No courier mail should be sent to this address.

5. The Blood Center may assess the Client a late payment charge on any amount which remains unpaid after it is due, computed at the rate of one and one-half percent (1-1/2%) per month on the balance which remains unpaid or at the maximum rate permitted by law, whichever is less; provided, however, the Client shall not be assessed the late payment charge on amounts disputed in good faith if the Client provides the Blood Center with a detailed written description of any disputed amounts within ten (10) calendar days of the date of the invoice and pays undisputed amounts in a timely manner.

6. The Client shall reimburse the Blood Center its reasonable costs of collection, including attorney fees, in the event the Client defaults in the payment of any amounts due under this Agreement.

7. The Blood Center may assess additional service fees for additional testing of blood products required by standard of care, standard industry practice, and the FDA. All new FDA mandated tests will be invoiced to the Client with thirty (30) days notice.

III. COVENANTS

A. The Blood Center shall:

1. Fully comply with the terms and conditions of this Agreement.

2. Fully comply with all provisions of law applicable to the Blood Center;

3. Provide standard requisition and report forms, upon request, to the Client;

4. Pay the surcharge required under Indiana's Medical Malpractice Act of 1975, as amended, to the Department of Insurance and remain qualified as a Health Care Provider under said Act;

5. Keep in force at all times, during the performance of this Agreement, a policy or policies of insurance in an amount not less than that required of it as a qualified Health Care Provider by Indiana's Medical Malpractice Act of 1975, as amended;

6. Maintain professional liability insurance in the minimum amount of Five Million Dollars ($5,000,000.00), in any combination of primary and excess amounts, for each occurrence;

7. Upon request, provide the Client with a certificate of insurance evidencing that the coverage described in sub-sections 4 and 5 has been obtained;

8. At all times, be licensed by the Food and Drug Administration (FDA), the State of Indiana, and applicable state health care agencies;

9. At all times, be accredited by the AABB (American Association of Blood Banks) and the American Society for Histocompatibility and Immunogenetics (ASHI);

10. Perform all services provided hereunder in conformity with the Customer Resource Manual, standard of care, and standard industry practices as set forth by the FDA, AABB, ASHI, and the Clinical Laboratory Improvement Amendments (CLIA); and

11. Upon request, make available to the Client during an on-site audit, quality control information and proficiency testing or manufacturing processes or practices

results pertaining to any testing done by the Blood Center.

B. The Client shall:

1. Fully comply with the terms and conditions of this Agreement.

2. Fully comply with all applicable provisions of law relating to the licensing and regulation of like health care organizations, blood services and laboratories;

3. Upon request, provide the Blood Center with a certificate of insurance evidencing a policy or policies of insurance, in an amount not less than that required of it under applicable law; and

4. Fully comply with all provisions of law applicable to the Client.

IV. TERM

A. Except as otherwise provided in this Agreement, the initial term of this Agreement shall be for a period of three (3) years commencing on the Effective Date. Pricing will remain firm for the first one (1) year of this Agreement. The pricing for the subsequent years may be increased by a maximum of 3% each year. The Blood Center will notify the client thirty (30) days prior of any price increase(s) for any product, panel or individual test(s) listed in Exhibit A-1 and Appendix X.

B. Except as otherwise provided in this Agreement, either party may terminate this agreement by providing one-hundred eighty (180) calendar days written notice to the other party.

C. Either party may terminate this agreement upon an event of default by the other party by giving ten (10) calendar days written notice to the defaulting party, and provided such event of default is not cured within the ten (10) calendar day notice period.

D. Either party may terminate this Agreement, effective immediately upon giving written notice, if the other party is the subject of a criminal investigation by the FDA or any other governmental or regulatory agency.

V. EVENTS OF DEFAULT

A. If any one or more of the following events shall occur and be continuing, it is here defined as and declared to constitute an "event of default" or "default" under this agreement:

1. failure of the Client to make any payments when due;

2. failure to perform any Covenant in this agreement;

3. material breach of any covenant, representation or warranty provided by the

defaulting party under this agreement;

4. either party files a petition in bankruptcy, is adjudicated bankrupt or takes advantage of the insolvency laws of any jurisdiction, makes an assignment for the benefit of its creditors, is voluntarily or involuntarily dissolved or has a receiver, trustee or other court officer appointed with respect to its property; or

5. either party is the subject of a criminal investigation by the FDA or any other governmental or regulatory agency.

VI. MISCELLANEOUS PROVISIONS

A. Limitation of Liability. The Client acknowledges that the results of immunological and serological tests, even when properly performed by the Blood Center or its Third Party Laboratories, cannot be guaranteed or warranted by the Blood Center because of the occurrences of false positives or false negatives. The Blood Center does not, therefore, guarantee or warrant such tests.

B. Independent Contractor. It is understood by the parties that each party is an independent contractor with respect to the other party, and that each party and its employees are not an employee, agent, partner of, or joint venturer of the other party. This Agreement is not intended to constitute an agreement of hiring under the provisions of any Workers Compensation or unemployment compensation law, any local, state or federal employment law or any similar law, and it shall not be so construed. Each party agrees to accept full and exclusive liability for the payment of contributions or taxes including, without limitation, unemployment compensation contributions and local, state and federal withholding taxes, imposed under such laws by the federal and state government which are measured by remuneration which paid to such party's employees.

C. Force Majeure. The Blood Center shall use its best efforts to provide the blood services, blood product services, and blood testing services requested by Client, but the Blood Center shall not be liable for non-performance or delays or damages arising from such if caused by events beyond the Blood Center's control including, but not limited to, a shortage of supply of raw materials, manufacturing, delivery, acts of regulatory agencies, discontinuance of necessary products or unavailability of a service, war, riot, acts of God, or acts of public enemies.

D. Non-Discrimination. The Blood Center and the Client both agree not to discriminate in any way on the basis of race, color, sex, religion, national origin, or disability and that each of them otherwise uphold the laws of their state.

E. Omnibus Reconciliation Act of 1980 (P.L. 96-499) codified at 42 U.S.C. § 1395x(v)(I). In the event compensation payable hereunder shall exceed Ten Thousand Dollars ($10,000.00) per annum, the Blood Center hereby agrees to make available to the Secretary of Health and Human Services (HHS), the Comptroller General of the US General Accounting Office (GAO), or their authorized

representatives, all contracts, books, documents, and records relating to the nature and extent of the costs hereunder for a period of four (4) years after the furnishing of services hereunder. In addition, the Blood Center hereby agrees, if services are to be provided by subcontract with a related organization, to require by contract that such subcontractor make available to the HHS and GAO, or their authorized representatives, all contracts, books, documents, and records relating to the nature and extent of the costs thereunder for a period of four (4) years after the furnishing of services thereunder.

F. Health Insurance Portability and Accountability Act (HIPAA) Compliance. Blood Center agrees that any products or services provided under this Agreement will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to the Blood Center with respect to the services to Client under this Agreement, including but not limited to regulations promulgated under Title II Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-91) ("HIPAA"). Furthermore, Blood Center and Client shall promptly amend the Agreement to conform with any new or revised legislation, rules and regulations to which Blood Center is subject now or in the future including, without limitation, the Standards for Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Laws") in order to ensure that Blood Center is, at all times, in conformance with all Laws with respect to Client. If within 90 calendar days of either party first providing notice to the other party of the need to amend the Agreement to comply with Laws, the parties, acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate this Agreement upon 30 calendar days prior written notice to the other party. Blood Center shall mandate Blood Center's subcontractor, if any, comply with the requirements of this section.

G. Legislative Limitations. In the event federal, state or local laws, rules or regulations at any time during the term of this Agreement prohibit, restrict, or in any way substantially change the method of reimbursement for services under this Agreement, then this Agreement shall, in good faith, be amended by the parties to provide for payment or compensation in a manner consistent with any such prohibition, restriction, or limitation. However, such legislative limitations shall not affect the standard price/rate schedule for services under this Agreement. If this Agreement is not amended prior to the effective date of such rule, regulation or interpretation, this Agreement shall terminate as of such effective date.

H. Confidentiality. Neither party shall knowingly disclose any information developed or generated pursuant to performance under this Agreement without the other party's prior written consent, including the terms of the Agreement itself, except when compelled to do so by law. Further, the Blood Center shall not knowingly communicate directly with any Client customer or consignee. This confidentiality and non-disclosure provision shall survive termination of this Agreement.

I. Severability. If any provision of this Agreement shall be held to be invalid or unenforceable for any reason, the remaining provisions shall continue to be valid and enforceable. If a court finds that any provision of this Agreement is invalid or unenforceable, but that by limiting such provision it would become valid and enforceable, then such provision shall be deemed to be written, construed, and enforced as so limited.

J. Waiver. None of the terms of this Agreement shall be deemed to be waived by either party, unless such waiver be in writing and duly executed on behalf of the party to be charged with such waiver by its authorized officer and unless such waiver recites specifically that it is a waiver of the terms of this Agreement. The failure of either party to insist strictly on any of the terms or provisions of this Agreement shall not be deemed a waiver of any subsequent breach or default of its terms or provisions.

K. Applicable Law. This Agreement shall be governed by and interpreted and enforced in accordance with the internal laws of the State of Indiana. The parties hereby irrevocably and unconditionally consent to the exclusive jurisdiction of the courts of the State of Indiana and of the United States of America located in Marion County, Indiana (the "Indiana Courts") for any litigation arising out of or relating to this Agreement (and agree not to commence any litigation relating to this Agreement except in such Indiana Courts) and waive any objection to venue of any such litigation in the Indiana Courts.

L. Assignment. Except as otherwise provided herein, any assignments of this Agreement or the rights or obligations hereunder shall be invalid without the specific written consent of the other party.

M. Notice. Any notice required or permitted by this Agreement shall be in writing and shall be deemed delivered three (3) days after it is deposited in the United States Mail, postage prepaid, certified or registered mail, return receipt requested, addressed to the party to whom it is to be given as follows:

BLOOD CENTER: Indiana Blood Center
Byron B Buhner, President and CEO
3450 North Meridian Street
Indianapolis, IN 46208

cc: Mike Parejko, Executive VP/COO

CLIENT: Community Hospital South
Anthony Lennen, President
1402 East County Line Road South
Indianapolis, IN 46227

N. Entire Agreement. This agreement contains the entire agreement of the parties hereto and supersedes all prior agreements, contracts and understandings whether written or otherwise between the parties relating to the subject matter hereof. There exists no

other understandings, terms or conditions, written or oral, related to the rights and obligations established by this Agreement, and neither Party has relied on any representation, express or implied, not contained herein.

O. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

P. Amendments. This Agreement may only be modified or amended if the amendment or modification is made in writing and is signed by both parties.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Client and the Blood Center have duly executed this Agreement on the date first written above.

"Blood Center"
Indiana Blood Center

By: Byron B Buhner
Byron B. Buhner, President and CEO

6-27-13
Date

"Client"
Community Hospital South

By: A. B Lennen
Anthony Lennen, President

7-8-13
Date